OFFICE OF PROFESSIONAL REGULATION
VERMONT SECRETARY OF STATE

Professional Licensing Study

Mental Health Practitioners

December 2024

Executive Summary

In Act 117 (2022) and Act 77 (2023) the Legislature asked the Office of Professional Regulation to study the mental health professions in Vermont. The Office conducted this study over an 18-month period, contacting over 100 stakeholder organizations and interacting with approximately 2,000 individual stakeholders.

Thematic Findings and Recommendations

At the highest level, this study has four main findings:

1. OPR's regulatory structure of the mental health professions would benefit from a vertical consolidation/reorganization.

Collectively, the mental health professions are one of OPR's largest professional blocs, but also the Office's most regulatorily dispersed field. Currently there are two credentials under the Board of Psychological Examiners, three credentials under the Board of Allied Mental Health, and 8 credentials under the advisor model. Likewise, OPR will soon begin regulating four new mental health credentials in the creative arts therapies and peer support roles. This regulatory "sprawl" is a consequence of the organic growth of mental health regulation over time: with new modalities and professional disciplines slowly added to OPR's jurisdiction.

OPR recommends that greater efficiency is possible through a more vertical organization:

- Expand the BAMH umbrella to include the advisor mental health professions to improve consistency in rulemaking representation in enforcement decisions; and
- Add all new mental health credentials to the expanded Board of Allied Mental health
- Establish an Executive Office of the Mental Health Boards to improve efficiency in license administration and rulemaking for all mental health professions

2. It's possible to streamline entry-level qualifications without lowering professional competency requirements.

The general requirements for licensure are relatively consistent across Vermont's mental health professions, but there are still profession-specific rules which create unnecessary burdens for professionals and professionals-in-training.

OPR identifies a number of strategies to simplify and standardize rules with other states:

- Expand the education coursework supplementation pathways to licensure;
- Reduce redundant exams required for licensure;
- Eliminate arbitrary supervised practice rules; and
- Reduce overly burdensome continuing education requirements

3. **Additional regulations for supervisors can support both the quality of, and provider interest in, clinical supervision services.**

Currently, Vermont's only qualification for clinical supervisors is at least three years of active practice. Despite this very low requirement, there is still a shortage of willing professionals.

OPR recommends rules to promote supervision quality and protect trainees and supervisors:

- Standardize supervision contract language;
- Standardize supervisor evaluations for independent practice; and
- Standardize supervisor continuing education

4. **OPR finds that there are barriers to licensure into the mental health professions for individuals from marginalized groups.**

Unintended barriers to access are obstacles that can hinder marginalized groups from fully participating in society, even when there are no explicitly discriminatory policies in place. In professional licensing, marginalized groups experience unintended barriers simply because the rules and regulations weren't made with their group/social circumstances in mind.

OPR identifies barriers to entry into the mental health professions for marginalized groups:

- For many applicants, the difference between an acceptable education and an acceptable degree is an insurmountable hurdle (i.e., *the paper ceiling*);
- There is a lack of accommodations in licensing exams for applicants; and
- There is a lack of representation among Vermont's clinical supervisors

Future Work

The Office of Professional Regulation acknowledges that despite extensive outreach efforts, the Office was not successful in engaging individuals from all of Vermont's marginalized communities. Likewise, OPR recognizes that streamlining the regulation of a field as broad and complex as the mental health professions is no simple endeavor. Accordingly, OPR proposes a 2028 regulatory impact assessment of this study, to review:

- The consolidated mental health board's functionality;
- The role of the executive officer of the mental health boards;
- Impacts of this report to reduce burdens on mental health professionals;
- Impacts of this report to improve supervision quality and access;
- Impacts of this report to improve barriers for marginalized groups;
- The potential need for a general counseling credential; and
- Any other regulatory changes OPR and the mental health boards deem necessary.

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Introduction & Background

In the United States nearly one in four adults—approximately 58 million people—live with a mental illness.[1] Despite the prevalence of mental illness, there is a shortage of mental healthcare providers: nearly half of all Americans live in areas with a lack of access to care.[2]

Vermont ranks 12th in the nation regarding mental illness and access to care, and Vermonters are experiencing a national trend: *with a growing demand for mental health services, a shortage of mental health providers, and an increase in out-of network participation, the system is built such that only people with higher incomes can afford to receive care*.[3]

Ultimately, two forces are stretching the mental healthcare provider workforce: 1) the growing demand for mental health services, and 2) an inadequate supply of new entrants into the mental healthcare professions. Consequently, organizations across the country are now more closely studying the licensure process for mental health providers.[4]

Likewise, Vermont's General Assembly passed Act 177 (2022) requiring the Office of Professional Regulation to conduct this Mental Health Professional Licensure Study:

> *The Office of Professional Regulation shall conduct a study on:*
>
> *(1) the possibility of streamlining the licensure of mental health professionals practicing in the State, including a review of the feasibility of creating one mental health professional license with endorsements for specific mental health professions;*
>
> *(2) whether additional regulation of supervisors for mental health professionals in training is necessary, including a review of potential limits on areas of mental health work a supervisor may supervise based on the supervisor's own work experience and education, the rate or fee a supervisor may charge for providing supervision, and the number of supervisees assigned to one supervisor; and*
>
> *(3) the barriers for individuals who are Black, Indigenous, or Persons of Color (BIPOC), refugees and new Americans, LGBTQ individuals, individuals with low income, individuals with disabilities, and those individuals with lived mental health and substance use experience entering mental health professions regulated by the Office of Professional Regulation.*[5]

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[1] Langenhahn & Deluce, 2023.
[2] Ibid.; Health Resources and Services Administration, 2023.
[3] Reinert, M. et al., 2022: 29; KFF, 2024.
[4] O'Conner et al., 2019 & 2020; Norris & Thom, 2023; NCSL, 2023; Changelab Solutions, 2024; Musburger et al. 2024.
[5] Act 117 (2022) is available online here: https://legislature.vermont.gov/Documents/2022/Docs/ACTS/ACT117/ACT117%20As%20Enacted.pdf

Study Methodology

This study was an 18-month process, beginning in July of 2023 and ending in December of 2024. Throughout this period OPR endeavored to include as many stakeholders as possible and collect feedback from all available (and often conflicting) perspectives. OPR utilized the S.O.A.R. strategic planning framework (an analysis of *strengths*, *opportunities*, *aspirations*, and *results*) to empower stakeholders to lead discussions around the current and proposed rules affecting their respective mental health professions. These meetings occurred 1 to 4 times per month, for 10 months. OPR distilled the feedback from these discussions into anonymous surveys for licensed professionals, professionals in training, and also individuals whose applications for licensure in a mental health profession were denied. The findings in this report reflect the feedback OPR collected throughout this process.

Outreach Efforts

Act 117 Sec. 8(b) directs OPR to conduct outreach and include as many stakeholder groups as possible in the process of this study.

> *(b) Stakeholder input. The Director of the Office of Professional Regulation shall seek the input and recommendations of the following stakeholders in completing the study:*
>
> *(1) representatives of each mental health care profession associated with the Office of Professional Regulation, selected by their respective licensing board or by the Director;*
>
> *(2) the Commissioner of Mental Health or designee;*
>
> *(3) the Chair of the Health Equity Advisory Commission established pursuant to 18 V.S.A. § 252 or designee;*
>
> *(4) representatives of mental health care professional organizations and a representative of Vermont Care Partners;*
>
> *(5) representatives of health insurers;*
>
> *(6) individuals in mental health care professions or seeking to enter mental health care professions, selected by AALV, Inc., the Vermont Commission on Native American Affairs, the Vermont Center for Independent Living, and Outright Vermont; and*
>
> *(7) other interested stakeholders, including individuals from diverse backgrounds to represent the interests of communities of color and other historically underrepresented populations in mental health care professions.*

In total OPR's public outreach included the following:

- Phone and email campaigns to over 100 stakeholder organizations[6]
- 24 public meetings with boards and stakeholder groups
    - Over 160 invitees
- 1,784 survey participants[7]
    - Translated in 14 languages
    - Licensed professionals
    - Professionals-in-training
    - Applicants denied licensure

Study Limitations

This study is subject to a number of limitations, not the least of which was OPR's reliance on unpaid volunteer participation. A lack of funding to compensate participants likely impacted this study in three ways: a response bias by participants with stronger feelings than the average demographic member; a lack of representation from individuals for whom the current system works well, and; an exclusion of individuals who could not afford to participate in unpaid activities during normal business hours.

Consequently, the Office of Professional Regulation acknowledges that despite extensive outreach efforts, the Office was not successful in engaging individuals from all of Vermont's marginalized communities. Although OPR identifies a number of barriers to the mental health professions in this study, findings on that subject are considered incomplete.

Future study of the barriers to entry into licensed professions for Vermont's marginalized groups will require funding and resources which were not available to OPR for this project. The Office of Professional Regulation does not possess sufficient expertise in areas of equity and access and would benefit from review by an outside expert. For example, this study illuminated for OPR a critical lack of accommodations on our own website for individuals with disabilities or non-English language preferences. The Office recognizes the likelihood that there are additional, more complex barriers for which further work is necessary.

Moving forward, the Office of Professional Regulation will continue to evaluate barriers to best of our limited ability. Likewise, OPR will continue to pursue partnerships with the Office of Racial Equity (ORE), as well as other state departments and community organizations, to ensure inclusivity in Vermont's rules and regulations. The Office invites the general assembly to discuss with OPR and ORE the value of funding a 3rd party expert to assist in this effort.

[6] State agencies and bodies, Vermont professional organizations, national professional organizations, healthcare organizations, insurers, Vermont community organizations, education programs, and regulatory agencies in other jurisdictions. See Appendix A.
[7] Survey available in Appendix B.

Streamlining: to simplify or standardize (i.e., make uniform) a process

Part 1: Streamlining Mental Health Professional Licensure

Act 117 instructs the Office of Professional Regulation to conduct a study on the possibility of streamlining the licensure of mental health professionals practicing in Vermont. This study evaluates the potential for streamlining at two separate levels of analysis:

1. The organizational level, i.e., state agency/board structure; and
2. The programmatic level, i.e., profession-specific rules and regulations.

At the organizational level, the Office of Professional Regulation is an "umbrella agency" comprised of 14 professional licensing boards (51,000 licensees) and one large advisor pool complete with profession-specific advisors (32,000 licensees).[8] At the time of this report's drafting, OPR is regulating nearly 11,000 active state licenses across eight distinct mental health professions and 13 credential types, including multiple board and advisor models.

Part 1(a) of this study evaluates how OPR can more efficiently organize mental health regulatory programs.

Part 1(b) examines the qualification standards for mental health professionals and explores possible rule changes to simplify or standardize license requirements.

[8] Professional licensing boards are public bodies whose members are appointed by the Governor. Boards generally meet just once a month during which time board business may be discussed in accordance with public meeting law. In daily operations, OPR executes board policies, except where board decisions are required. In the advisor model there is no public body, and advisors are appointed by the Secretary of State. In daily operations, OPR's Director interprets and applies applicable law and regulation in consultation with the appointed advisors.

Part 1(a): Streamlining at the Organizational Level

The collective mental health professions represent one of OPR's largest professional populations: surpassed in number only by the Board of Nursing. The mental health professions are closely followed in size by Notaries Public (an advisor profession), the Boards of Pharmacy, and the Board of Professional Engineering.

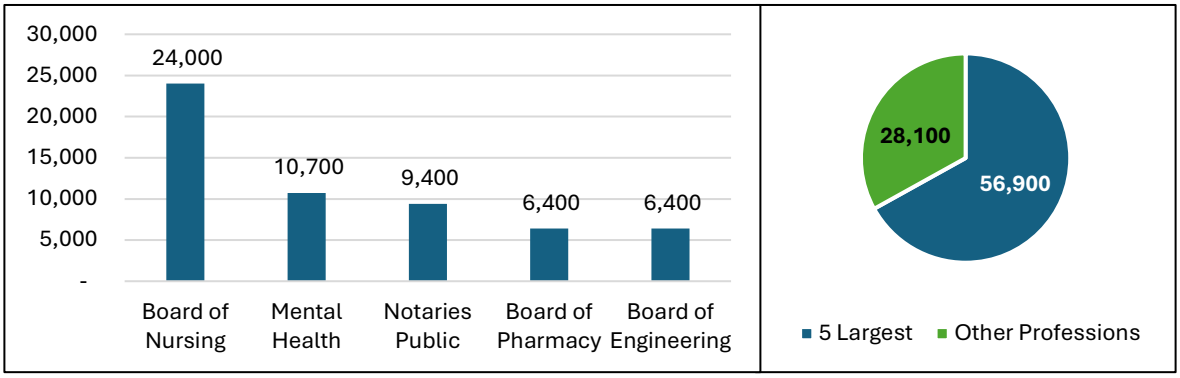

Figure 1: The mental health professions are OPR's 2nd largest professional bloc. OPR's five largest fields comprise 2/3rd of OPR's total licensure. Rounded to the nearest hundred.

The mental health professions comprise approximately 13% of OPR's total licensure. The collective size of the mental health professions is somewhat concealed, not only by their dispersion across OPR's board and advisor models, but also due to the diversity of mental health credentials which OPR regulates. Currently, OPR issues 13 different mental health professional credentials, of which two are regulated by the Board of Psychological Examiners, three are regulated by the Board of Allied Mental Health, and eight are advisory professions.

Table 1: OPR's current mental health licensure by board, profession and credential type.

Model	Board/Advisory	Professional Credential	Approx. Count
Boards	Allied Mental Health	Licensed Clinical Mental Health Counselor (LCMHC)	2,700
		Marriage and Family Therapist (MFT)	420
		Non-licensed/non-certified psychotherapist	2,025
	Psychological Examiners	Doctoral Psychologist	1,215
		Master's Psychologist	200
Advisors	Social Work	Master's Social Worker	230
		Licensed Independent Clinical Social Worker (LICSW)	2,900
	Psychoanalysts	Psychoanalyst (PSYA)	70
	Applied Behavior Analysts	Assistant Behavior Analyst	260
		Applied Behavior Analyst (ABA)	15
	Alcohol & Drug Abuse Counselors	Apprentice Addiction Professional	100
		Certified Alcohol & Drug Abuse Counselor	25
		Licensed Alcohol & Drug Abuse Counselor (LADC)	500
		Total Mental Health Licensure	**10,660**

In addition to the existing mental health professions, the general assembly recently assigned four new mental health credentials to the Office of Professional Regulation's jurisdiction: Music Therapists, Art Therapists, and Peer Support Providers and Peer Recover Support Specialists. As a result, it is likely that OPR's total number of mental health professionals will soon reach 11,000 licensees.

Topic 1: A Single Mental Health Credential is not Feasible

Act 117 specifies that OPR must study the possibility of streamlining the licensure of mental health professionals practicing in the State*, including a review of the feasibility of creating one mental health professional license with endorsements for specific mental health professions*.

While OPR regulates over a half dozen separate mental health professions, the distinguishing quality of each discipline's approach/specialty are lost on the average consumer. Similarly, as discovered throughout this study process, professional regulators are also not immune to confusion about the gaps and overlaps in mental health modalities. Undoubtedly, the allure of a single, all-encompassing mental health credential stems from a perception of simplicity.

Stakeholder Feedback

Study participants unanimously oppose the single mental health professional credential. Profession-members were quick to explain the relevant and differentiating features in each mental health profession's philosophies and corresponding approaches to care. Additionally, stakeholders cited the importance of professional identity and the inevitable confusion for both professional applicants and clients alike.

Perhaps most importantly, study participants cited the challenges for license mobility to other states if Vermont were to abandon the nationally recognized titles. With the growing reliance on interstate licensure compacts, the consolidated mental health credential would jeopardize Vermont's ability to join compact agreements, thereby limiting Vermonters' access to countless qualified mental health professionals from other compact-member states.

Recommendation

The Office of Professional Regulation agrees with study participants that a single mental health professional license is simply not feasible. From an administrative perspective, there are no benefits to be gained from license consolidation. "Therapy" in the realm of mental health practice may sound like a singular service, but there is not one overlapping area of practice from which to create specialty branches. Unlike OPR's professions which do utilize a singular credential with specialty pathways, e.g., Professional Engineers and Advanced Practice Registered Nurses, the mental health professions do not share the same educational requirements or entry exams from which to build upon.

Rather than consolidating the mental health professions into a single credential, OPR instead recommends consolidating the mental health regulatory programs into a more vertical structure within the existing "umbrella".

Topic 2: Expand the Board of Allied Mental Health

Professional licensing boards have two primary roles: 1) setting entry-level qualification standards for their respective professions, and 2) adjudicating misconduct complaints against the professionals under their jurisdiction. As such, professional licensing boards are primarily comprised of profession-members whose profession-specific knowledge provides the necessary subject matter expertise involved with those aforementioned responsibilities.

However, as evidenced by both the necessity of public members on boards, as well as the prevalence of "umbrella" boards which oversee multiple related professions, licensing boards need not be profession-specific or comprised solely of profession-members.[9] As OPR wrote in its 2020 Regulatory Assessment Report:

> *Profession-specific boards are given to seeing their worlds as unique, but on the ground, most of the principles of professional conduct are generalizable across fields, and most actionable disciplinary complaints concern frank misconduct, not nuanced questions of technical judgment.*[10]

From an administrative perspective, the umbrella board structure is beneficial because it facilitates the standardization of both qualification standards and conduct enforcement across multiple professions at once. This is accomplished through shared business process management, policy coordination in administrative rules, and the same board members participating in all enforcement decisions.

Notably, most states have at least one mental health umbrella board among their mental health boards. At least thirteen states regulate LCSWs, LPCs, and LMFTs under a single board. At least 17 LCSW boards, 37 LPC boards, and 35 LMFT boards are composite (i.e., regulating several professions). In many cases, these composite boards also regulated some other related behavioral health professions, such as Addiction Counselors, Pastoral Counselors, Behavior Analysts, and more rarely, Psychologists.[11]

The Board of Allied Mental Health (BAMH) is OPR's mental health umbrella board. Unlike the Board of Psychological Examiners, which regulates only Psychologists, the BAMH is currently responsible for three separate mental health credentials: Clinical Mental Health Counselors, Marriage and Family Therapists, and Non-Licensed and Non-Certified Psychotherapists. The

[9] Knepper et al., 2022;Slivinski, 2020; LeBuhn, 2016.
[10] https://sos.vermont.gov/media/whqjyp2o/regulatory-structures-report-january-2020.pdf
[11] Examples of mental health umbrella boards in other states are available in Appendix C

addition of the four advisory mental health professions (i.e., Social Work, Alcohol & Drug Abuse Counseling, Applied Behavior Analysis, and Psychoanalysis) would simplify OPR's efforts to establish consistency across all mental health professions' entry qualification standards and professional conduct enforcement actions.

Stakeholder Feedback

All stakeholders are concerned about sufficient board representation. Study participants were generally in favor of expanding the Board of Allied Mental Health, with the caveat that OPR ensure adequate representation for each profession. Naturally, professionals from the current advisory groups were strong proponents of board membership in the hopes of greater representation. Likewise, professionals already licensed under the Board of Allied Mental Health, were cautiously supportive so long as they did not lose representation.

Psychologists do not want to join a consolidated mental health board. Psychologists, the Board of Psychological Examiners, and the Vermont Psychological Association expressed indifference to expanding the BAMH with the advisor professions, but presented strong opposition to merging their own board with that of Allied Mental Health.

> *As the legislature considers moving toward an "umbrella board model" for mental health, I would ask that they consider the complexity of understanding the specialties within each profession…As a psychologist, I would find it difficult to address issues brought up in a social work board meeting – I have not been trained to look at issues through the lens of a social worker. I imagine my colleagues in the other professions would find it equally difficult when addressing issues specific to psychology.*

Recommendation

The Office of Professional Regulation recommends expanding the Board of Allied Mental Health to include all mental health professions from the advisory professions. To accommodate the additional professions under the Board of Allied Mental Health, the board's composition must change. The Office of Professional Regulation proposes expanding the board's membership to 12 seats, allocated based on professional population size:

Table 2: Proposed Composition of the expanded Board of Allied Mental Health

Professions	Board Seats	Licensure
Social Workers	3	3,130
Clinical Mental Health Counselors	3	2,700
Alcohol and Drug Abuse Counselors	2	625
Marriage and Family Therapists	1	420
ABA, PSYA, CAT, PSS, PRSS*	2	345**
Public Members	1	
*Applied Behavior Analysts, Psychoanalysts, Creative Arts Therapies (Music Therapists and Art Therapists), Peer Support Specialists, Peer Recovery Support Specialists **Figure does not include counts from CAT or CPS (not yet licensed)		

With this expanded composition, the Board of Allied Mental Health may need to employ *ad hoc* members to ensure representation in enforcement cases against profession-members from which there is not currently a board member professional, or in the event that the sole board profession-member has recused. OPR's licensing boards often rely *on ad hoc* members for a variety of reasons, and this scenario will not be unique or irregular. However, if OPR determines that the ad hoc approach is insufficient in nuanced cases of professional practice, the Office may propose advisory sub-committees as found in other states.

Although there are operational efficiencies which could be gained by consolidating the Board of Psychological Examiners with the Board of Allied Mental Health, OPR does not recommend doing so at this time. As OPR implements the expansion of the Board of Allied Mental Health, the Office will evaluate the transition's impacts, and will continue discussions with the Board of Psychological Examiners on the topic of a potential future consolidation with the larger mental health board. In the interim, OPR recommends that many of the same efficiencies can be achieved by use of an Executive Officer of Mental Health Professional Regulation.

Topic 3: Add an Executive Officer for Mental Health Professional Regulation

Executive Officers advance OPR's primary mission of public protection by supporting the Office's four pillars of professional regulation: licensure, practice, enforcement, and continuing education:[12]

- The EO functions as a subject matter expert regarding scope of practice for all license types within their profession;
- The EO functions as a subject matter expert to License Administrators related to applications, and assists with determining qualifications or disqualifying events;
- The EO supports the work of enforcement by providing information and resources that speak to established practice standards, scope of practice, or professional conduct;
- The EO serves as a resource for students, education program faculty, and workforce administrators through formal presentations and personal communications related to regulation, licensing, and practice.

The Office of Professional Regulation currently utilizes two Executive Officers in the fields of Nursing and Pharmacy. In both cases, these fields' diversity and complexity demand an administrator whose subject matter expertise can coordinate state policy, perform applicant qualification evaluations, and mitigate operational bottlenecks by managing responsibilities that would otherwise fall on OPR's general counsel, the deputy director, and/or the boards.

Similar to both the fields of pharmacy and nursing, OPR's mental health professions are comprised of a large number of professionals, including over a dozen distinct professional

[12] A full explanation of the Executive Officer role is available in Appendix D.

credential types: each with their own related but unique scopes of practice, education qualification standards, and fields of specialization.

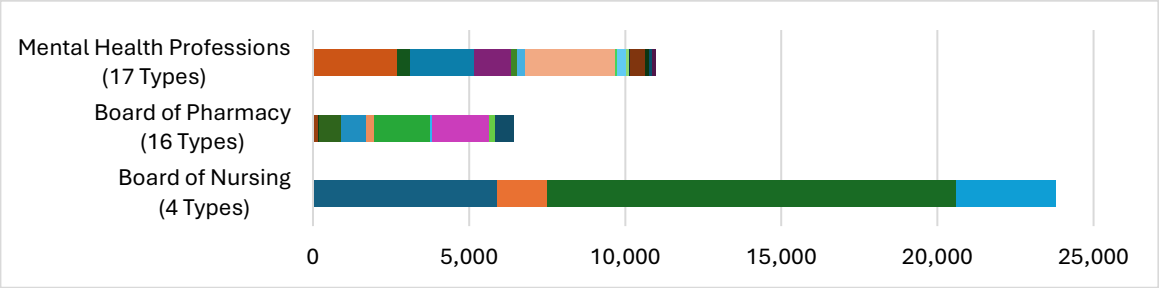

Figure 2: Comparison of the population size and credential types in the mental health, nursing, and pharmacy professions.

An Executive Officer of the Mental Health Boards

Mental health professions require specific and complex coursework and degree program requirements in order for an applicant's education to qualify for licensure (for more information see *Part 1(b)*).

The education evaluation is an onerous, time-consuming process which currently requires board review and slows the rate at which OPR can issue mental health licenses. The education evaluation process is precisely why OPR's mental health advisor professions are often more efficient at processing initial applications for licensure than board professions: OPR performs the education qualification determination in real-time whereas boards meet just once a month.

Because both of OPR's mental health boards spend a significant portion of their time reviewing applicants' education, the education review process represents a significant bottleneck in application approvals. To mitigate this issue, the Board of Allied Mental Health currently employs a 3rd party contractor to perform education evaluations. However, an executive officer with subject matter expertise could serve this role for all mental health professions, removing the need for a 3rd party contractor and allowing boards to focus on their primary responsibilities of standards settings and conduct enforcement.

Additionally, an EO would assist OPR's General Counsel's office to maintain rules and regulations current with emerging practices. Because executive officers work on the forefront of professional practice, EOs maintain an awareness of new trends within their fields. An Executive Officer of Mental Health Professional Regulation would identify the statute or rule changes necessary to ensure alignment between regulations and best practice standards. In this regard the EO provides subject matter expertise to the General Counsel, assisting in advocacy for statute or rule revisions, as well as drafting testimony to legislative committees.

Stakeholder feedback

Stakeholders were generally supportive of an Executive Officer role to facilitate the regulation of mental health professions. Professionals and board members alike acknowledged the benefits that an EO position could offer OPR, especially to facilitate rulemaking.

Board members expressed concern about the EO's proposed license administration duties. Currently board members are responsible for education qualification determinations, and some board members are nervous to allow an EO to assume this role. However, these concerns were somewhat assuaged when OPR clarified that licensing boards will continue to set minimum qualification standards for their licensed professionals. In this respect, the EO position is a partner to the boards, implementing the boards' rules and standards, and still bringing complex cases to the boards when additional support is necessary.

Recommendation

The Office of Professional Regulation recommends the addition of an executive officer (EO) role to oversee OPR's regulation of mental health professionals. Despite this new role, OPR's mental health licensing boards would continue to set qualification standards for applicants. Simply put, the Executive Officer would be responsible for implementing these standards: working with license administrators to perform education qualification determinations, and designing remedial coursework pathways to licensure for applicants whose education does not yet meet Vermont's requirements (See *Topic 6: Streamlining Opportunities in Post-graduate Education Rules*). Additionally, the EO of Mental Health Professional Regulation would respond to inquiries from licensees, work with partners in other states/at national organizations, and recommend policy changes to OPR and Vermont's mental health boards.

Consistent with OPR's other executive officer class descriptions, OPR recommends the following language:

> *Managerial and consultative work at a professional level for the Secretary of State's Office of Professional Regulation in providing services to the State Board of Psychological Examiners, State Board of Allied Mental Health, and the State mental health professional community. Within limits of delegated authority, an incumbent carries out administrative, consultative and investigatory duties for the Board. Significant interaction occurs with the Boards, education programs, consumers of mental health services, regulated individuals, and the mental health provider community, including employers. Supervision is exercised over professional, clerical and temporary staff. Work is performed under the general direction of the Assistant Director of the Office of Professional Regulation.*

Topic 4: Restructure the Roster of Non-licensed & Non-certified Psychotherapists

Psychotherapy is a protected practice, meaning that only those mental health professionals with licenses to practice psychotherapy may do so. For example, psychotherapy is the primary protected practice within the scopes of practice of Psychology, Clinical Social Work, Clinical Mental Health Counseling, and Marriage and Family Therapy.

6 V.S.A. § 4082 defines the practice of psychotherapy:

> *"Psychotherapy" means the provision of treatment, diagnosis, evaluation, or counseling services to individuals or groups, for a consideration, for the purpose of alleviating mental disorders. "Psychotherapy" involves the application of therapeutic techniques to understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behavior that interferes with effective emotional, social, or mental functioning. "Psychotherapy" follows a systematic procedure of psychotherapeutic intervention that takes place on a regular basis over a period of time, or, in the case of evaluation and brief psychotherapies, in a single or limited number of interventions.*

When necessary, restricting market access through entry-level qualification standards is an effective approach to reducing the risk of harm caused by unskilled practice. To that end, the Roster of Non-Licensed and Non-Certified Psychotherapists represents an exception among OPR's regulated mental health credentials—the Roster is a simple registration system which permits registrants to sell psychotherapy services despite no prerequisite qualifications.

Act 222 of 1993 first established the Roster, stating:

> *It is the intent of this chapter:*
> *(1) To ensure that consumers of psychotherapy services are provided with the information relating to the training and qualification of non-licensed and non-certified providers of psychotherapy necessary to enable them to make informed decisions concerning their choice of providers.*
> *(2) That psychotherapists who are non-licensed and non-certified are entered on a roster and practice according to established standards of professional conduct and be subject to disciplinary procedures if they fail to adhere to those standards.*[13]

The concept of the Roster is not uncommon, and most states provide some form of statutory carveout permitting non-licensed and non-certified individuals to provide psychotherapy services. In Vermont, Roster members must provide a mandatory consumer disclosure to would-be clients regarding their education, experience, and unlicensed/uncertified nature. It is ultimately the consumer's responsibility to decide, *caveat emptor*, if a potentially untrained, inexperienced individual can be trusted with the most intimate, traumatic, or otherwise challenging aspects of said consumer's life.

[13] 1993, No. 222 (Adj. Sess.), Sec. 17

However, since its inception the function of Vermont's Roster has evolved—and not necessarily for the better. While the Roster continues to provide an avenue for uneducated and untrained individuals to practice psychotherapy services, the registration has become a bureaucratic "catch-all" for the psychotherapy professions generally. Today, all professionals-in-training from the psychotherapy professions must join the Roster in order to engage in supervised clinical practice. This means that the roster is now comprised of three distinct groups: 1) highly educated post-graduate supervisees; 2) uneducated and unsupervised registrants; and 3) semi-qualified practitioners whose education and training is insufficient for professional licensure, and for whom Vermont's current rules do not offer a viable pathway to achieve professional licensure.

Stakeholder Feedback

Licensed stakeholders advocate for differentiating trainees from the roster. In addition to questioning why the Roster exists at all, numerous study participants highlighted their support for distinguishing highly educated and supervised trainees from potentially uneducated and unsupervised providers: *A provisional* [trainee] *license would differentiate for the public between supervised trainees and unsupervised, untrained individuals.*

Licensed stakeholders advocate for trainee credentials. Nearly all study participants who are licensed mental health professionals or representatives from professional associations, strongly support profession-specific credentials for the supervised clinical practice hours.

> *Creating an associate license for marriage and family therapists would be beneficial to the MFT profession in Vermont. An associate license is meant for those who have completed a graduate degree and are working on completing the supervised experience required for full licensure. This designation would increase employment opportunities for new marriage and family therapists and thus increase the number of highly trained and qualified mental health providers in the state. An associate license creates a clear path toward licensing and would standardize Vermont licensure laws with those of many other states.*

Stakeholders who are mostly qualified for licensure feel stranded on the Roster. Many professionals-in-training complete their supervised practice hours only to learn that their education is not sufficient for licensure in Vermont. Due to Vermont's strict rules around "acceptable" degrees and limited coursework supplementation, many of these applicants face the choice of beginning an entirely new graduate degree, remaining on the Roster forever despite the significant earnings/career impacts, or leaving the field entirely (for more information see *Topic 6: Streamlining Opportunities in Post-Graduate Education Rules*).

> *I was missing a course called "Diagnosis" but had courses that covered it in Canada that were not accepted. I had a masters in school counseling and in psychological counseling and a certification in special care counseling. I remained on the roster my entire 40 years of practice. Just retired.*

Recommendations

The Office of Professional Regulation recommends establishing "trainee" credentials for all mental health professions with relevant supervised practice requirements. OPR's licensing software already uses a "-TRNE" credential suffix structure in other professions, which will function well for the purpose of the mental health professions.

Additionally, the Office of Professional Regulation recommends renaming the Roster for Non-Licensed and Non-Certified Psychotherapists to the "Roster for Non-Licensed and Non-Certified Wellness Advisors." OPR does not recommend any other changes to the scope of practice or mandatory disclosure for rostered individuals.

Establishing a trainee credential for each mental health profession, as well as renaming the Roster, will resolve three issues:

1. Enforcement cases will be heard by the trainees' professional licensing board, rather than the Board of Allied Mental Health (BAMH). Currently, all rostered individuals fall under BAMH jurisdiction even if the trainees' scopes of practice pertain to the psychology or social work professions.
2. Removing "psychotherapist" from the roster's credential title will further differentiate for consumers the highly educated and trained professionals from potentially untrained and uneducated providers. OPR is concerned that by including "psychotherapy" in the title of the Roster credential, consumers may misconstrue those individuals as qualified to provide psychotherapy. The recommended title "Roster of Non-licensed and Non-Certified Wellness Advisors" cannot be easily misconstrued as any other licensed mental health profession.
3. Trainee credentials will resolve complications related to CMS guidelines for supervised practice reimbursement.[14]

Lastly, the Office of Professional Regulation recommends establishing post-graduate coursework supplementation pathways to reduce absolute barriers to licensure for individuals who have "unacceptable" degrees and are permanently "stuck" on the Roster. Likewise, the Office recommends a sunrise analysis as part of a larger regulatory impact assessment report due January 2028, evaluating the need for a general counselor license for individuals whose graduate education in professional counseling does not qualify for the new coursework supplementation pathways into any of the licensed psychotherapy professions. For more information see *Topic 6: Streamlining Opportunities in Post-Graduate Education Rules*.

[14] Center for Medicare & Medicaid Services; The combined roster creates complications for reimbursement and resulted in limited reimbursement periods for professionals-in-training.

Topic 5: Add Certification Pathways for Creative Arts Therapies

Pursuant to Act 77 (2023), OPR must create a process for the certification of Music Therapists and Art Therapists.[15] Previously, the Office has performed three preliminary assessments for licensure, i.e., *Sunrise Reviews*, between the art and music therapy professions.[16] The 2021 Preliminary Sunrise Music Therapy Assessment report states:

> OPR finds that regulation of music therapists is necessary to protect the public from the single harm of deception or misrepresentation by untrained individuals claiming to provide music therapy. The least restrictive form of regulation to address this harm is a certification of the profession. OPR recommends that, to address this harm and potential similar harms in other types of creative art therapies and to ensure cost-effective and efficient regulation, the General Assembly establish a holistic, creative arts therapy certification for professionals that use creative art forms as therapeutic treatment modalities, including music therapists.

Throughout this study period OPR worked with stakeholders from the Art Therapy and Music Therapy professions to determine qualification standards for state certification.

Stakeholder Feedback

Art and Music Therapists prefer profession-specific certifications. At the very least, stakeholders recommend the umbrella term "creative arts therapies."

> *We want to ensure that if the board structure uses an umbrella category which includes Music Therapists and Art Therapists (and keeps the category open to other professions such as Dance and Movement Therapy in the future) that it be called Creative Arts THERAPIES (not creative arts therapists, as this is not a codified profession that exists).*

However, stakeholders argued that a single, all-encompassing credential may create challenges for Vermont resident professionals trying to endorse to other states.

Art and Music Therapists are concerned about title and scope protection. Stakeholders fear that the certification scheme, which is voluntary, does not adequately protect the public or distinguish between qualified and unqualified service providers.

> *We continue to be concerned that the certification level of regulation does not protect the title "Music Therapist" - that an individual would still be able to call themself a "Music Therapist" even if they do not have the required national credential of a Board-Certified Music Therapist (MT-BC). We feel this does not adequately protect the public.*

[15] Act 77 (2023) Sec. 12

[16] OPR's sunrise reports are available here: https://sos.vermont.gov/opr/regulatory/regulatory-review/

Similarly, stakeholders shared frustration that without the scope protection of a professional license, non-certified music and art therapists are still free to practice in Vermont.

Art and Music Therapists recommend their respective national certification bodies. Stakeholders suggested that Vermont should adopt the national standards of the Art Therapy Credentials Board (ATCB) and the Certification Board for Music Therapists (CBMT).

Recommendations

If the General Assembly adopts the Office's recommendation in *Topic 2* to expand the Board of Allied Mental Health (BAMH), OPR recommends that Music and Art Therapists be added to the expanded board with separate, profession-specific certifications. If the General Assembly does not adopt the Office's recommendation for BAMH expansion, the Office recommends the certification of Music and Art Therapists within the advisory professions under a "Creative Arts Therapies" profession title and separate, profession-specific credential certifications.

The Office recommends Vermont adopt the ATCB and CBMT certifications as Vermont's certification qualification standards.

Part 1(b): Streamlining Profession-Specific Requirements

Part 1(a) of this report is focused on streamlining at the organizational level, for which the bulk of recommendations require some form of statutory change to implement. In contrast, Part 1(b) of this report is focused on streamlining profession-specific requirements which exist in, and can therefore be modified by, administrative rulemaking. Where Part 1(a) provided specific recommendations to the legislature per Act 117 requirements, Part 1(b) instead offers thematic recommendations for board rulemaking consideration.

In this section, OPR aims to provide an objective analysis of the costs and benefits of any policy alternatives, with the intention of further discussion with boards and profession-members throughout the rule making process.

The goal of programmatic streamlining is not to force different professions to meet the same exact requirements, but to standardize the philosophy and approach to qualification standards generally. Notably, the Office of Professional Regulation and various national professional associations have already achieved some success in this area: despite different credentialing, the pathways to licensure in most mental health professions tend to follow the same regulatory "landmarks".

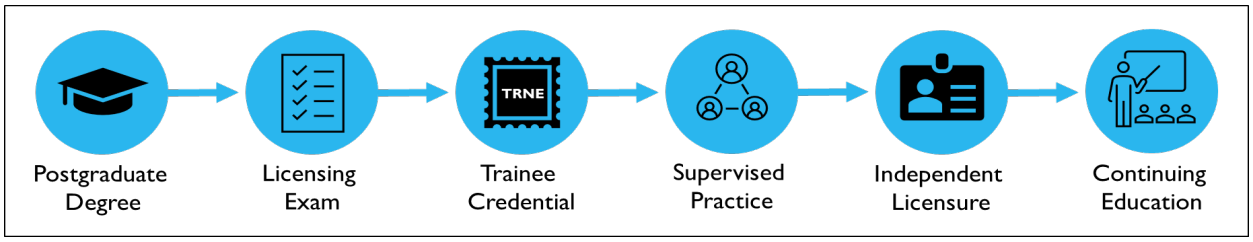

Figure 3: Regulatory requirements are relatively consistent across mental health professions, although the order of these events may vary somewhat by individual and profession.

For example, nearly all mental health providers, regardless of profession type, must obtain a qualifying post-graduate education, a passing score on a licensing exam, and complete supervised practice hours. To this extent, the regulatory hurdles in the mental health professions are already somewhat streamlined.

In the following sections, this report reviews additional efforts that OPR and the mental health boards can take to further streamline rules and regulations.

Topic 6: Streamlining Opportunities in Post-Graduate Education Rules

Some of OPR's mental health professions require a graduate degree or certificate from an accredited program, e.g., Social Workers, Psychoanalysts. In these professions, the national accrediting bodies have successfully standardized most, if not all, profession-specific education programs across the country. Accordingly, there is very little additional

streamlining possible in these profession-specific education requirements, because OPR does not manage accreditation standards.

Accreditation is very helpful in professional regulation: it guarantees for OPR that an applicant's education is at least substantially equivalent to our minimum requirements, and that no further education evaluation is necessary. However, accreditation is a costly process and many programs around the country cannot afford to become accredited. OPR does not recommend accreditation-only pathways except where accreditation organizations have already achieved *total market capture*, i.e., complete coordination with education programs.

"Acceptable" Degree Rules Create Arbitrary & Absolute Barriers

In the mental health professions which permit both accredited and non-accredited degree pathways to licensure, a distinction is made between "acceptable" and "non-acceptable" degrees.[17] Although counterintuitive, an acceptable degree determination does not necessarily mean the applicant's graduate education is sufficient for licensure. Rather, applicants with acceptable degrees simply have board approval to supplement their education with any missing coursework. "Unacceptable" degrees may not be used towards licensure, and require applicants to begin entirely new education programs.

Table 3: Coursework requirements and post-degree supplementation allowances for "acceptable" degree determinations in the Clinical Mental Health Counselor profession.

Min. Education Qualifications for Licensure	"Acceptable" Degree	Post-Degree Supp.
Total Credits Required for Licensure	60 credits	
Min. Graduate Program Credit Requirements	n/a	
Min. Prescribed Graduate Coursework	**18/60 credits**	**21/60 credits**
DSM - Diagnosis, Assessment, and Treatment	3 credits	no
Human growth and development	3 credits (5/7)	(2/7)
Counseling Theories	3 credits (5/7)	(2/7)
Counseling Skills	3 credits (5/7)	(2/7)
Groups	3 credits (5/7)	(2/7)
Measurement/statistical methods/research	3 credits (5/7)	(2/7)
Professional Orientation and Ethics	3 credits (5/7)	(2/7)
Treatment Modalities	3 credits (5/7)	(2/7)
Multi-cultural Studies		3 credits
Research and evaluation		3 credits
Career Development & Lifestyle Appraisal		3 credits
Marriage, Couples, and Family Counseling		3 credits (2/5)
Human sexuality		3 credits (2/5)
Crisis intervention		3 credits (2/5)
Addictive disorders		3 credits (2/5)
Psychopharmacology		3 credits (2/5)

[17] I.e., Psychology, Clinical Mental Health Counseling, and Marriage And Family Therapy.

For example, licensure as a Clinical Mental Health Counselor (LCMHC) requires 60 credits of graduate coursework, but an acceptable degree determination only specifies 18 credits and allows up to 21 credits in post-degree supplementation. However, a course on the Diagnostic and Statistical Manual of Mental Disorders (DSM) is the only steadfast requirement for an LCMHC degree program. Any two of the seven core courses may be supplemented so long as the applicant has achieved at least any five. The obvious question follows: if applicants can supplement any two of these courses, why can't they supplement all of them?

From a regulatory perspective, the "acceptable" degree restriction lacks evidence for the barriers it creates: there is no empirical evidence to suggest that an applicant who supplements any areas of coursework—before passing a licensing exam and completing 3,000-4,000 hours of supervised practice—is more likely to provide a quality of care which fails to meet the prevailing standards of practice. Further, while the "acceptable" degree standards are seemingly arbitrary, the consequences are significant: applicants whose graduate degrees are considered "unacceptable" by their licensing board, have no pathway towards Vermont licensure except to begin an entirely new graduate education.

Licensing boards are expected to mandate specific education requirements for licensure. However, the inability for applicants to supplement their existing education to meet those standards, creates an absolute barrier for which there is no work-around. This absolute barrier not only prevents career laddering into the mental health professions from adjacent fields (e.g. school guidance counselors) but is also very likely to disproportionately affect individuals from Vermont's marginalized communities (discussed in *Part 3: Topic 18*).

Inequitable Licensing Standards: The Vermont-Resident Disadvantage

Many non-resident professionals are able to obtain Vermont licensure without meeting the entry-level standards to which OPR currently holds Vermont resident applicants.

In most professions, applicants who have been actively licensed and practicing in another jurisdiction for at least three years may obtain Vermont licensure through the *fast-track endorsement process* (3 V.S.A. § 136a).[18] The fast-track process functions as universal license reciprocity for experienced practitioners: these applicants may obtain Vermont licensure without any qualification evaluation. The general assembly established the fast-track pathway as an effort to increase the number of licensed professionals working in the state. **However, the fast-track endorsement process creates a disparity in opportunity for Vermont's resident applicants: fast-track offers a pathway to licensure for experienced non-resident professionals who may not meet Vermont's entry-level qualifications.**

[18] There is no fast-track endorsement pathway for applicants in the Alcohol and Drug Abuse Counseling professions, or for Master's Psychologists. More information on the fast-track endorsement pathway is available here: https://sos.vermont.gov/opr/regulatory/reducing-barriers/fast-track-endorsement/

For example, consider the Doctoral Psychologist credential: Vermont requires applicants to prove their degrees include 33 credits of board-prescribed coursework, and at least 400 course hours total. Yet, education requirements in some states are far more flexible than those in Vermont. West Viriginia rules state that doctoral degrees must be issued by departments with "psychology" in the name, and do not prescribe coursework by credit count, simply stating that required graduate level coursework must include: *clinical interviewing, diagnosis and treatment planning, psychopathology, biological bases of behavior, ethics, assessment of children and adults, individual psychotherapy, clinical practicum, clinical internship, and tests and measures*.[19] Similarly, Kentucky prescribes specific graduate credit requirements by course subject, like Vermont, but allows applicants to supplement any required coursework missing from their doctoral program.[20]

Currently, there are Doctoral Psychologists practicing in Vermont with endorsements from both West Virginia and Kentucky—and Vermont is happy to have them. Nevertheless, Vermont resident applicants are clearly held to a higher standard than non-resident applicants. Ironically, Vermont resident applicants who are denied a pathway to Vermont-licensure based on an "unacceptable" degree, may pursue licensure in a more lenient state and then endorse back to Vermont after three years of practice, if they ever choose to return. An obvious question follows: **if Vermont will accept three years of experience in lieu of equivalent degree requirements, why wouldn't we allow non-qualifying resident applicants to supplement an additional 3 years of supervised practice in Vermont?**

Likewise, the proliferation of interstate licensure compacts creates a regulatory environment wherein licensed professionals from other compact-member states may practice in Vermont without needing a Vermont license. While Vermont maintains our authority for professional conduct enforcement within our jurisdictional boundaries, OPR does not evaluate the qualifications of compact-member professionals. For example, Vermont joined the Interstate Counseling Compact in 2023, and it is likely that non-resident professionals will work in Vermont with an identical scope as their resident peers, though without having met the same qualification standards Vermont imposes on its own licensees.

Stakeholder Feedback

Stakeholders want Vermont's entry-level pathways to licensure to more closely match the opportunities offered to experienced non-residents. Participants expressed frustration that resident applicants are held to different qualification rules than non-residents: *Vermont* [professionals] *are being held to a higher standard and have increased barriers to becoming licensed in the state in which they live and work*.

[19] West Virginia's rules are available here: https://psychbd.wv.gov/license-info/Pages/default.aspx
[20] Kentucky's rules are available here: https://psy.ky.gov/new_docs.aspx?cat=101&menuid=117

Stakeholders feel that supplementation restrictions are overly burdensome. Numerous study participants expressed frustration that they couldn't supplement existing qualifications from their post-graduate educations:

1. *I asked for a letter of deficiency to evaluate my transcripts and allow me to supplement, and I was told I had to get a whole new degree. I have 13 years of counseling experience. Now, I have only 6 months left to my provisional license to stay on the roster, and all I hear are outcries about 1.) The shortage of therapists 2.) The difficulty of attracting people to Vermont. I am here I am qualified.*
2. *I currently have my Master's Degree and have been running my own Private Practice for two years and am unable to get licensed because my Psychology degree is lacking 400 hours of internship. I was informed that I would need to get an entirely different Master's Degree rather than make up the 400 hours under Supervised Practice. I think allowing Supervised hours or just an internship would prevent barriers. I have no interest in paying for another Master's Degree and have contemplated leaving the field due to this.*
3. *I believe that if someone has successfully graduated from a college/university and they are missing certain classes, they should be able to take those classes post-graduation regardless of what they are missing. They should not have to enroll in an additional graduate program.*
4. *So I have a basically useless Master's…I can't afford to get another degree, with $95,000 in student loans sitting there on income-based repayment at $0 payment a month for years. I'm locked into this place.*
5. *Yes, I had completed an online master's program through SNHU, in which was not licensed eligible, when I decided to pursue becoming licensed rather than being able to supplement or pursue options to meet the requirements the program had not offered, I had to complete a whole second master's program and none of the supervised hours I had participating in were able to count towards licensure until I completed the second program.*

Stakeholders identified supplementation restrictions as a barrier to career laddering. Many study participants who work/worked in adjacent professions described absolute barriers to licensure despite having obtained most of the qualifying coursework for clinical licensure.

1. *Supplementation and career laddering opportunities would greatly streamline the process and encourage more professionals to pursue licensure in a time in which mental health services is in high demand.*
2. *I have a Masters in School Counseling. If I want to get trained and licensed to be a Clinician, I have to start over with that Master's program, which is 60 more credits. In NY, you only need to take four more classes (16 credits). So at my age of 66, I can't start from scratch again, and it's prevented me from being able to be a Clinician in an area of the state that really needs extra Clinicians!!!!*

3. *There are too many roadblocks for people who are looking to get into this profession, specifically those who have an almost parallel degree. The fact that someone who has a master's degree in school counseling and is licensed in school counseling from another state, is not able to move to this state and just take the necessary courses to complete their clinical mental health degree is outrageous to me.*

Stakeholders worry course supplementation weakens professional competency and professional identity. Although there was strong support for increasing the number of pathways to licensure, multiple study participants expressed fear that allowing applicants to supplement missing qualifications would lower the general competency of the profession.

> *It is critical that licensed mental health professionals are trained at the level they are currently. Poor quality of care, poor boundaries do great harm. The state of the field has been watered down and is losing respect. Please keep the requirements as stringent as they are now.*

Likewise, some board members agreed with the need for expanding supplementation opportunities, but "only within reason". All board members expressed a concern for the unique approaches in each mental health profession, and argued that someone who has piecemealed together a graduate education in psychotherapy may be qualified to provide counseling services, but may not be qualified to do so specifically through the lens of a Psychologist, Clinical Mental Health Counselor, Marriage and Family Therapist, or Independent Clinical Social Worker. As one board member stated:

> *I'd be more comfortable with establishing a new, general practice counseling credential than watering down our profession's current requirements.*

Rule Considerations

The Office of Professional Regulation encourages the Director and boards to implement post-graduate education rules that provide remedial opportunities rather than impose absolute barriers. Specifically, boards should consider expanding course supplementation pathways to licensure for applicants whose degrees do not meet the "acceptable" degree coursework requirements. This is especially important for applicants whose education and expertise in adjacent professions (e.g. school psychologists and counselors) would require relatively little coursework to transition onto the clinical licensure track and begin supervised practice.

However, OPR also acknowledges the importance of distinction in clinical approaches. OPR frequently receives applications for licensure from individuals whose graduate education does not neatly meet existing professional standards, but whose training would likely allow that individual to safely practice psychotherapy generally. OPR recommends an impact assessment report of this study's recommendations due in January 2028, including a sunrise analysis of a general counseling credential, with a specific focus on qualification standards and clear coursework supplementation pathways. This credential may help to reduce the use

of the Roster (see *Topic 4*) and expand Vermont's mental health professional workforce without sacrificing the established approach and identity of existing professions.

Topic 7: Streamlining Opportunities in Licensing Exam Requirements

Licensing exams are one of the three primary qualification standards in most mental health professions (in addition to qualifying education and supervised practice). The Office of Professional Regulation does not design or proctor licensing exams for mental health professionals. Rather, professional associations and/or accrediting organizations are responsible for designing and maintaining profession-specific competency exams.

Stakeholder Feedback

Stakeholders propose Vermont limit the number of licensing exams. Throughout this study, participants have made clear that the cost of licensing exams is high. Even if applicants pass an exam on their first attempt, some professionals must pass multiple exams for licensure. For example, Licensed Clinical Mental Health Counselors must pass both the *National Counselor Exam* (NCE) as well as the *National Clinical Mental Health Counseling Exam* (NCMHCE). However, as study participants were quick point out, no other states in New England or New York require both exams for licensure as Clinical Mental Health Counselors.[21]

Similarly, during this study period the Association of State and Provincial Psychology Boards (ASPPB) released their newest exam: the *EPPP Part 2*. The ASPPB intended for all states to begin requiring both *EPPP* exams for licensure. However, after significant pushback from states across the country about the burden a second exam would place on applicants, the ASPPB is now considering whether to combine the two exams. Future ASPPB meetings will determine the outcome of the EPPP exam(s).

Stakeholders propose that Vermont consider alternatives to licensing exams. Many stakeholders expressed frustration with licensing exams as poor indicators of the applicant's knowledge and skills to practice.

1. *The exams did not feel like they were measuring my competency to provide mental health counseling services as much as they felt like they were measuring my ability to take a test. Much like the SAT's or similar exams. I would like to see the examination requirement eliminated from the licensure process.*
2. *From what I have learned/read the exam is not valid in terms of assessing the readiness or quality of a therapist's abilities to practice. Perhaps having an option for assessing a therapists' abilities through observation (i.e. mock session observation) would be better suited for this profession rather than relying on a standardized test.*

[21] LCMHC state requirements are available here: https://www.nbcc.org/search/stateboarddirectory

For example, study participants identified the Illinois Board of Social Work, which allows applicants who failed the *Association of Social Worker Boards* (ASWB) LCSW exam to obtain licensure after an additional 3,000 hours of professional experience.[22] Likewise, in its 2023 Periodic Review of Behavioral Health, the Utah Department of Commerce recommended the state "*reduce barriers to entry while maintaining high standards of safety and competence for practitioners by providing an alternate pathway that accepts additional supervision hours and recommendations in lieu of clinical exams*."[23]

Additionally worth noting, is that multiple stakeholders cited research findings that the ASWB LCSW exam contains inherent biases, an issue to which the National Association of Social Workers responded:

> *The National Association of Social Workers (NASW) opposes the Association of Social Work Boards (ASWB) social work licensing exams after a review of ASWB data shows significant disparities in pass rates for prospective social workers of color, older adults, and those who speak English as a second language.... NASW is prepared to oppose the Social Work Interstate Compact Legislation being developed by the Council of State Governments (CSG) if the bill is not substantially improved, including the removal of provisions which codify the ASWB exams.*[24]

This issue is discussed further in *Topic 19: Barriers in Licensing Exams for Marginalized Groups*.

Rule Recommendations

The Office of Professional Regulation encourages the Director and mental health boards to consider whether the current exam requirements are necessary to ensure provider competency, and if additional alternative pathways to licensure are possible. Similarly, OPR encourages the Director and boards to consider how current exam requirements may unfairly burden Vermont resident applicants, given the variable exam requirements across jurisdictions and non-resident pathways to licensure via interstate compacts and *Fast-track*.

Topic 8: Streamlining Opportunities in Supervised Practice Rules

Supervised practice is essential for mental health professionals-in-training.[25] During this period, trainees practice under a licensed professional who not only assumes vicarious responsibility for the trainee and their clients, but also serves as a professional mentor providing specific feedback on the trainee's practice. Arguably, supervised practice is a more

[22] Illinois' exam alternative pathway policy is available in Appendix E.
[23] OPLR 2024: Page 8, Recommendation 2a. Available online here: https://oplr.utah.gov/wp-content/uploads/2024/01/OPLR-2023-Periodic-Review-Behavioral-Health-1.pdf
[24] February 2023. Available here: https://www.socialworkers.org/News/News-Releases/ID/2611/NASW-Opposes-Association-of-Social-Work-Boards-ASWB-Exams
[25] Note, rules pertaining to supervisors are discussed separately in *Part 2* of this report.

effective regulatory qualification standard than either education qualifications or exam scores, as trainees are able to directly demonstrate their competence and readiness for independent practice.

Table 4: Clinical supervised practice rules for OPR's psychotherapy professions. Emphasis added to highlight the primary inconsistencies targeted in stakeholder feedback.

	Psych.	LCMHC	MFT	LICSW
Total Supervised Practice Hours Needed	4,000*	3,000	3,000	3,000
Minimum Direct vs. Indirect Service Hours	no indirect	2,000:1,000	1:1:1 couples, family, indirect	2,000:1,000
Total Supervision Hours Needed	200	100	100	100
Maximum Practice to Supervision Hours	40:2/20:1	30:1	30:1	30:1
Max Group to Individual Supervision Hours	1:1 weekly	50:50	50:50	50:50
Max group supervision size (n. trainees)	no	6	6	8
Permanent HIPPA Compliant Remote Supervision rules?	no	no	no	Yes
Minimum number of supervisors necessary	2	n/a	n/a	n/a
Maximum weekly practice hours	40	no	no	no
Maximum supervision accumulation rate	Min. 1 year	Min. 2 years	Min. 2 years	1,500 annually
Minimum hourly practice accumulation rate	700/year	No	No	16/week
Supervised Practice Hours Expiration Period	5 years	5 years	5 years	50% in 5 years

*Psychology rules allow up to 2,000 hours during graduate program, requiring a minimum of 2,000 post-graduate supervised practice. NOTE: ASPPB recommends "*The entire supervised experience, including practica, internship, and face-to-face supervision must total a minimum of 3,000 hours*."

Stakeholder Feedback

The total numbers of supervised practice hours vary somewhat by profession, but in all cases, Vermont's requirements fall well within each profession's national norms. As such, study participant feedback was primarily focused on the challenge of obtaining supervision in Vermont, and how arbitrary rule restrictions create additional barriers for trainees.

Stakeholders would like more guidance and simpler, more flexible rules. Study participants overwhelmingly stated that the current supervision rules are unnecessarily complex and burdensome:

- **Supervised Practice vs. Practicum vs. Internships** – study participants expressed confusion over the differences in experiential learning requirements, when these hours must occur (i.e., pre- or post-graduation) and the inconsistent rules therein across all licensed mental health professions.
- **Hourly Accrual Restrictions** – study participants expressed frustration at supervision accrual rules, citing the restrictions as arbitrary and irrelevant. For example, psychologist professionals-in-training must obtain at least 700 hours of supervised practice per year in order for those hours to qualify towards licensure. Similarly, despite a 1:1 ratio, psychologists-in-training may not count group supervision hours if they have not yet obtained their individual supervised hour in that week. Likewise, social workers in training may only earn 1,500 hours of supervised practice each year towards their license, and must obtain at least 16 hours per week in order for those hours to count towards licensure.
- **Group Supervision Size** – study participants expressed frustration at inconsistencies in group supervision size restrictions across professions. Participants noted that supervision groups often include trainees from multiple professions, and varying group size restrictions make this a challenge.

Stakeholders want remote supervision. With the exception of social workers, for whom HIPAA-compliant remote supervision was already permitted, all mental health professions adopted a remote-supervision policy in response to the COVID-19 pandemic. Mental health boards have since extended this policy on multiple occasions, and study participants have provided nearly unanimous support for these emergency policies to be made permanent. As one professional association aptly states: *Individuals can receive psychotherapy remotely, so it seems artificial to impose an in-person requirement on the supervision relationship.*

Stakeholders would like to be able to record supervised practice sessions with consenting clients. Currently, 18 V.S.A. § 9361(d) prohibits telehealth providers from recording patient consultations. Clinical supervisors and professionals-in-training suggest that recording practice sessions would benefit the training process and allow supervisors to better guide their trainees' development.

> *I provided clinical supervision for pre-licensed clinicians, many of whom are exclusively providing telehealth services, in an effort to keep expenses down as they are building their practice. Being able to audio or video record sessions and review them during supervision is one of the most robust learning tools available.*

Rule Considerations

The Office of Professional Regulation recommends that mental health boards consider simplifying supervised practice rules to maximize flexibility and access for trainees:

1. Adopt the psychology model where internship/practicum hours may be supplemented as direct service, postgraduate supervised practice hours;
2. Adopt the LCMHC/MFT model which establishes total individual and group supervision hours, including ratio of supervision to practice hours, without prescribing minimum accrual rates;
3. Adopt the LICSW model where supervision groups are limited to 8 individuals;
4. Adopt the LICSW model where 50% of practice hours may occur prior to 5 years before application; and
5. Adopt the LICSW model where HIPAA-compliant remote supervision is a permanent option for supervisors and trainees who prefer it.

Table 5: Example of one approach to simplifying supervised practice rules for the psychotherapy professions.

	Psych.	LCMHC	MFT	LICSW
Total supervised practice hours needed	4,000	3,000*	3,000*	3,000
Minimum direct vs. indirect service hours	no indirect	2,000:1,000	1:1:1 couples, family, indirect	2,000:1,000
Total supervision hours needed	200	100	100	100
Maximum practice to supervision hours	30:1	30:1	30:1	30:1
Maximum total group hours	100	50	50	50
Max group supervision size (n. trainees)	8	8	8	8
HIPAA-compliant remote supervision?	Yes	Yes	Yes	Yes
Minimum number of supervisors necessary	2	n/a	n/a	n/a
Supervised practice hours expiration period	50% in 5 years	50% in 5 years	50% in 5 years	50% in 5 years
*Additional direct service, post-graduate supervised practice hours may be necessary to supplement for missing internship hours from “unacceptable” degree paths.				

The Office of Professional Regulation recommends 18 V.S.A. § 9361(d) be amended to permit recording for training purposes, with client consent. Supervisors are not always able to participate or actively watch a trainee’s remote practice. Allowing trainees to record their practice is an effective way to improve the supervisor’s quality of supervision.

Lastly, the Office of Professional Regulation is concerned that many of the current rule restrictions in supervised practice create disproportionate barriers for individuals from Vermont's marginalized communities (discussed further in *Topic 20: Barriers to Supervised Practice for Marginalized Groups*).

Topic 9: Streamlining Opportunities in Continuing Education Requirements

Continuing education (CE) requirements are intended to ensure that licensed professionals are maintaining their existing professional competence while also gaining the knowledge and training necessary for evolving trends in professional practice. Act 117 of 2022 recently mandated that all mental health professionals now take 1 hour of CE related to cultural competency each biennial cycle:

> *Continuing education requirements shall include requiring one or more continuing education units in the area of systematic oppression and anti-oppressive practice, or in related topic areas, consistent with the report recommendations from the Health Equity Advisory Commission required pursuant to 2021 Acts and Resolves No. 33, Sec. 5 for improving cultural competency, cultural humility, and antiracism in Vermont's health care system*.

Additionally, Act 117 also established remote CE coursework as an acceptable format: *Synchronous virtual continuing education credits shall be approvable and accepted as live in-person training*.

Current CE Hour Requirements

Table 6: Current CE requirements in Vermont's mental health professions.

Profession Type	CE Hours	Required CE Hours by Topic
Licensed Clinical Mental Health Counselor	40	anti-oppression (1); ethics (4)
Licensed Marriage and Family Therapist	20	anti-oppression (1); ethics (4)
Non-Licensed & Non-Certified Psychotherapist	0	
Psychoanalyst	20	anti-oppression (1);
Psychologist - Doctorate	60	anti-oppression (1); ethics (6); no more than 30 hours per 1 topic
Psychologist - Master		
Licensed Independent Clinical Social Worker	20	anti-oppression (1); ethics (1.5)
Licensed Master's Social Worker	10	
Apprentice Addiction Professional	0	
Certified Alcohol & Drug Abuse Counselor	0	
Licensed Alcohol & Drug Abuse Counselor	40	anti-oppression (1); ethics (6); substance abuse disorders (12)
Applied Behavior Analyst	32*	anti-oppression (1); ethics (4)
Applied Behavior Analyst Assistant	20*	anti-oppression (1); ethics (4)
* CE is only required for board-certified professionals as part of their voluntary certification with the Behavior Analyst Certification Board (BACB).		

For the most part, Vermont's CE hour requirements for mental health professionals are consistent with those in other states. A notable exception, however, are the CE rules for Psychologists, which are substantially higher than any other mental health profession in Vermont, as well as those in most other states.

Stakeholder Feedback

Stakeholders feel that most CE requirements are too high, and overly burdensome. Study participants also frequently expressed frustration that CE requirements are not consistent across all psychotherapy mental health professions, despite similar scopes of practice.

1. *I don't understand why LICSW's only need 20 hours of CE's (Continuing Education hours) per 2-year cycle, and LCMHC's need 40 hours, when we are working side by side in the same organizations, holding the same positions (such as Outpatient Clinician), and working with the same clients. It would make sense to me that there be consistency in the Continuing Education requirements for these licenses.*
2. *While continuing education is essential for maintaining up-to-date skills, the total number of hours could be reassessed, especially if the requirement is higher than needed to ensure competency. Reducing the number of CE hours would help lessen the burden on professionals, particularly those balancing work and personal responsibilities*
3. *I would also appreciate if trainings that are approved by the NASW (National Association of Social Workers) would automatically be considered as approved trainings towards the LCMHC license, the way trainings approved by other professional organizations automatically count as approved trainings towards the LCMHC license…Given the LICSW and LCMHC scopes of practice overlap so much, I would think trainings that are approved for one would also be approved for the other. It would simplify the process of getting needed LCMHC CE hours!*

Stakeholders feel that CE requirements create a redundant cost burden. Study participants overwhelmingly noted that continuing education is expensive. Although study participants praised the shift to remote-CE formats, study participants suggested that high CE hourly requirements push professionals to find the cheapest trainings, rather than the most helpful for their practice. Stakeholders also expressed frustration that the required anti-oppression and ethics coursework often result in stale, redundant coursework. Instead, participants suggest that professionals should be trusted to pursue CE where necessary for their practice, as a matter of professional responsibility.

1. *The 40 CE requirement might encourage collecting hours by any cheap means possible. The professionals will seek training regardless of CEs and requirements.*
2. *Number of CE hours, cost, and CE redundancy are all barriers to entry and also barriers for maintaining practice. Vermont offers very few in-person, anti-oppressive, modern-practice trainings for our profession. What is offered is often not up to date or beneficial for current practice.*

3. *As previously mentioned, I feel the requirement that social workers complete extended racial biases continuing education in addition to ethics training is redundant and unnecessary.*

Rules Considerations

The Office of Professional Regulation recommends that the Director and boards consider limiting continuing education requirements to reduce regulatory burdens. To be clear, regardless of CE requirements, licensed professionals are expected to maintain professional competence with the prevailing and evolving standards of practice. High CE requirements do not guarantee professional competence but do ensure a burden for mental health professionals. Generally, OPR does not recommend prescribing specific coursework for professionals outside of those mandated by the general assembly. Instead, OPR prefers that professionals pursue the professional development most useful for their individual practices.

OPR recommends boards consider any of the following possible CE rule changes:

1. CE provided by or approved by the *National Board for Certified Counselors*, the *American Counseling Association*, the *American Mental Health Counseling Association*, the *American Psychological Association*, or *the American Association of Marriage and Family Therapists*, should be approved for all psychotherapy professions without prior review of the board(s);
2. Reduce all psychotherapy professions' hourly CE requirements to match the LICSW 20-hour requirement;
3. Reduce compact-member professions' hourly CE rules to match the lowest compact-member state's hourly CE requirements;
4. Require supervisors to obtain 4 CE hours related to supervision (see *Topic 13: Supervisor Qualifications*); and
5. Allow asynchronous coursework to qualify for CE hours.

Part 2: Additional Regulations for Supervisors

Act 117 (2022) directs the Office of Professional Regulation to study whether additional regulation of supervisors for mental health professionals in training is necessary, including but not limited to: *a review of potential limits on areas of mental health work a supervisor may supervise based on the supervisor's own work experience and education, the rate or fee a supervisor may charge for providing supervision, and the number of supervisees assigned to one supervisor.*

Topic 10: Limiting Supervision to Supervisor Areas of Expertise

Act 177 (2022) instructs OPR to perform a *review of potential limits on areas of mental health work a supervisor may supervise based on the supervisor's own work experience and education*. Notably, most regulated mental health professions which require supervised practice have already established administrative rules prohibiting supervision outside of the supervisor's professional area of expertise. For example, the Board of Psychological Examiner's administrative rule 4.4(c) states *Clinical supervision must be limited to areas in which the supervisor has sufficient education, training, and experience to provide meaningful guidance and be consistent with ethical standards for practice.* Likewise, Rule 9.1 of the Administrative Rules for Social Workers states that *Violation of the provisions of the N.A.S.W. Code of Ethics may constitute unprofessional conduct. T*he National Association of Social Workers' (NASW) Code of Ethics Rule 3.01(a) states *Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.*

However, even where administrative rules fail to include such provisions, 3 VSA 129a(a)(13) also states that unprofessional conduct includes *providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.*

Stakeholder Feedback

Stakeholders unanimously supported restricting professionals and supervisors alike from practicing outside their area of expertise. Happily, many study participants were able to cite the existing rules and ethical codes in their respective professions which already address this issue. Likewise, study participants provided anecdotal evidence that this type of misconduct does sometimes occur, and should be taken seriously.

Rule Considerations

The Office of Professional Regulation recommends that in addition to 3 VSA 129a, this issue can be effectively addressed in administrative rules. An administrative rule should be added to any mental health professions which do not currently have rules explicitly prohibiting clinical supervisors from supervising practice outside their areas of expertise.

Topic 11: Supervision Fee Rates

Act 117 (2023) instructs OPR to review *the rate or fee a supervisor may charge for providing supervision*. In Vermont, professionals-in-training may obtain supervised clinical practice in an organizational setting wherein supervision is both free and part of the trainee's employment.[26] While supervised hours are free in organizational settings, there is a limited number of trainee positions available, and both the caseload and nature of cases are outside the trainee's control. Alternatively, professionals-in-training may work in a private practice setting under the supervision of an independent professional, but at a significant additional cost to the trainee.

Stakeholder Feedback

Stakeholders were conflicted about supervision fee rates. The fee rate for supervised practice is one of this study's more contentious subjects. On the one side are stakeholders who feel cost of supervision in private practice settings is exorbitant and that OPR has a responsibility to restrict independent clinical supervisors from taking advantage of professionals-in-training. On the contrary, are stakeholders advocating on behalf supervisors, for whom there is significant risk involved with supervising new professionals: the supervisor's professional license takes on vicarious responsibility for all of their trainees' clients. Fortunately, all of the participants throughout this study (likely due to their work in the mental health fields) were incredibly respectful, excellent listeners, and deeply sympathetic to others' perspectives. Ultimately, all participants wanted an outcome which would be mutually supportive of both trainees and their supervisors.

Stakeholders acknowledged that the cost of supervision can create a barrier to entry:

> *It is important to note that obtaining supervision is a VERY expensive proposition for applicants. Although psychology applicants are required to get a total of 4,000 supervised hours, they generally get 3,000 or so of those hours post-degree (the rest they get through school internships). For 3,000 post-degree hours of supervised practice, for example, it could easily cost an applicant over $20,000 (3,000 hours divided by 40, times 2 hours of supervision for each 40 hours, times roughly $150 per hour for supervision). Some applicants for licensure are able to work in an organization, such as a designated agency, in which they can get supervision as part of their employment, but DAs tend not to have large numbers of psychologists and for the large group of applicants who start as a solo practice, the cost is a huge barrier to licensing. I have spoken to a few individuals who decided not to pursue a license because of that cost. Usually they just enroll on the roster and practice that way, which is fraught with its own dangers.*

[26] Organizational settings include but are not limited to designated agencies and special service agencies. More information is available at: https://mentalhealth.vermont.gov/individuals-and-families/designated-and-special-services-agencies

Stakeholders acknowledged that providing supervision is both an arduous and risky endeavor. Moreover, without private practice supervision, there would be insufficient training opportunities for new professionals:

> *It should also be stated that without adequate compensation for the added liability, the 24/7 availability for clinical support, and the significant additional time supporting supervisees outside of the supervisory hour, there is no reason a potential supervisor would or should make themselves and the resource of their hard-earned license available to supervisees at increased risk to themselves and at the sole benefit of the supervisee. There simply must be fair compensation for supervisors or the private practice option will disappear for supervisees. The people most impacted by this loss would be the supervisees themselves, and the many clients they serve.…In addition, the reality is that there are a limited number of agency jobs available in the state.…This means that without the private practice option, many mental health providers would likely be forced out of the state in search of positions or the opportunity to begin the private practice career they desire, which would only deepen the crisis in client access to services we are currently experiencing.*

Rule Considerations

The Office of Professional Regulation recommends against restricting fees for supervision. There is a fine line between regulatory intervention and regulatory interference. The Office of Professional Regulation engages in professional conduct enforcement but has never engaged in rate-setting for professional services. Instead, OPR prefers to allow market forces to determine professional service rates. The current height of supervision fee rates is unsurprising considering the reported shortage of clinical supervisors in Vermont. Rather than rate-setting, OPR recommends an attempt to reduce supervision costs by increasing the supply of qualified supervisors. Many of the recommendations throughout this report are designed to do just that: reduce barriers for qualified supervisors, encourage more in-state professionals to engage in supervision, and expand the qualified supervisor pool to include non-resident licensees through remote supervision.

Topic 12: Limiting Number of Trainees Per Supervisor

Act 117 (2023) instructs OPR to review *the number of supervisees assigned to one supervisor*. Currently, there are no rules regarding number of trainees a supervisor may have at a given time.

Restrictions on Supervisee Counts in Other States

The regulation of supervisors' trainee loads varies significantly by both profession and jurisdiction.

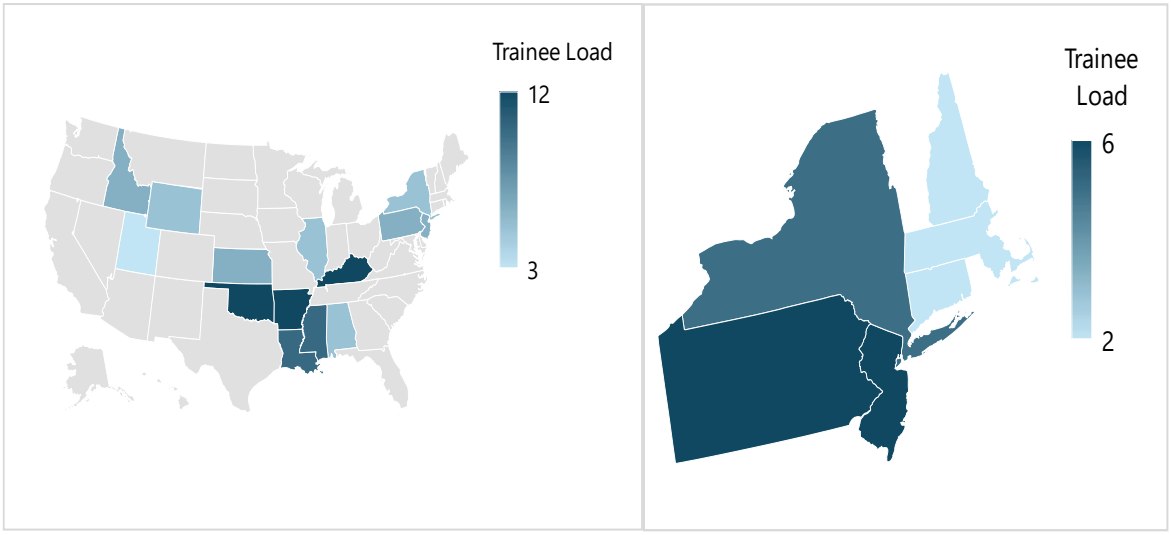

Figure 5: The number of trainees permitted per Clinical Mental Health Counselor supervisor across the US, and Marriage and Family Supervisors in the Northeast, respectively.

For example, in the Clinical Mental health Counselor profession, only 14 states limit the number of trainees that one supervisor may work with concurrently.[27] The maximum ranges from 3 trainees (UT) to 12 trainees (AR, KY, OK) with an average limit of 7 trainees per supervisor. However, Idaho specifies that their restriction does not apply to individuals whose primary role is to provide clinical supervision. Idaho's policy suggests an acceptance of the clinical supervision business model as a distinct and viable alternative to supervisors who provide supervision services in addition to their own clinical practice.

By comparison, the regulation of trainee loads for Marriage and Family Therapist supervisors is farm more common. In the northeast alone, Connecticut, Massachusetts, New Hampshire, New Jersey, New York, and Pennsylvania, all dictate the number of trainees an individual Marriage and Family Therapist supervisor may take on (range 2-6; mean 3.8).[28]

An alternative to restricting the number of trainees by count, is to restrict supervisors based on total supervised caseload. For example, the Association of State and Provincial Psychology Boards (ASPPB) recommends that *a supervisor shall not be responsible for the case supervision of more than three (3) full-time equivalent supervisees (full time equivalent equals 40 case hours per week) simultaneously for licensure*.[29]

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[27] Field et al., 2018

[28] CT rules (20-195a-3); MA rules (262 CMR 3.02); NH rules (MHP 306.02); NJ rules (13:34-3.3); NY Appendix A; PA rules (48.13).

[29] ASPPB Supervision Guidelines, 2020: p.14

Stakeholder Feeback

Stakeholder feedback is split regarding potential rules to limit supervisors' trainee loads. The primary concern in favor of additional regulation pertains to work quality: proponents suggest that without restrictions on the maximum number of supervisees per supervisor, Vermont is at risk of "supervision mills." Proponents fear there is a financial conflict of interest for supervisors to accept more trainees than they can reasonably supervise, and will lead to business models wherein licensed professionals spend all of their time supervising instead of directly engaged in clinical practice.

Opponents of additional regulations argue that licensed professionals who have a talent and passion for supervision should be able to pursue those roles as legitimate business models and may be able to provide a higher-quality supervision than professionals who offer supervision in addition to their full-time caseloads. Further, opponents of supervisee load restrictions suggest that OPR should encourage professionals to supervise during the current accessibility shortage.

Last but certainly not least, opponents of additional regulation argue capacity to supervise varies by professional, and each supervisor has a responsibility to acknowledge their own limitations:

> *While I appreciate the thought that the state would like to ensure supervisors do not take a load that would overwhelm their capacities, my experience is that this is not something that could be effectively or objectively managed by a third party.…A supervisor's capacities and preferences vary. Some supervisors, just like some therapists, thrive on working part-time and would benefit from carrying a smaller number of supervisees, while others thrive on working full-time and are able to offer more availability. This can vary person to person, and even over time for any one person. Ultimately, there is no more reason for an external party to regulate how many supervisees a supervisor sees than there is reason for a third party to regulate how many clients a therapist sees, how many patients a doctor sees, how many accounts a business consultant holds, etc. In fact, part of our professional training as clinicians is to understand that it is our ethical mandate to consider our own capacities, our own self-care, and our ability to provide high-quality care. Our training acknowledges that this responsibility falls, by necessity, squarely on the shoulders of the providers, themselves, because they are not objective issues. The onus is on the clinician, not the state, to manage these considerations, and given the massive variability individual to individual and situation to situation, it simply is not a matter that can be effectively managed externally.*

Rule Considerations

OPR recommends against regulating supervisee loads at this time. OPR was not able to find any empirical work to support restricting supervisor trainee loads on the basis of either

quality or safety, and therefore cannot satisfy 26 V.S.A. § 3105 criteria for increased regulation. The Office of Professional Regulation is already capable of enforcement actions against supervisors who fail to meet the standards of practice, which is historically rare. Lastly, boards must carefully consider the impact that restricting trainee loads may have on Vermont's already short supply of clinical supervisors.

Topic 13: Supervisor Qualifications

The qualification requirements for clinical supervisors of professionals-in-training are simple: applicants must have an active unencumbered Vermont mental health license, and at least 3 years of independent practice experience. A common question throughout this study was whether Vermont's experience criteria for supervisors is sufficient.

Who Can Supervise Whom?

Most mental health professions which practice psychotherapy allow for other psychotherapy professions to provide clinical supervision to trainees. The exception is the Board of Psychological Examiners, which requires that qualified supervisors be licensed psychologists in accordance with APA guidelines. However, while all other professions allow psychiatrists to provide supervision, only mental health counselors allow for nurse practitioners to provide supervision. In Vermont, nurse practitioners may practice independently within their fields, and there is no reason a psychiatric nurse practitioner could not provide clinical supervision to marriage and family therapists, social workers, or alcohol and drug counselors. Similarly, it is unclear why the current rules prohibit marriage and family therapists from supervising social worker trainees. Both of these examples are small inconsistencies in the current rules, which can be changed to help increase access to supervision.

Table 7: Current inter-profession supervision allowances in the psychotherapy professions.

		Trainees				
		Psych.	LMHC	MFT	LICSW	LADC
Possible Supervisors	Psych.	Y	Y	Y	Y	Y
	LMHC	N	Y	Y	Y	Y
	MFT	N	Y	Y	N	Y
	LICSW	N	Y	Y	Y	Y
	LADC	N	N	N	N	Y
	M.D./D.O.*	N	Y	Y	Y	Y
	NP**	N	Y	N	N	N

*Certified in Psychiatry
** Psychiatric Nurse Practitioner

Supervisor Specialty Endorsement

The Office of Professional Regulation currently offers a voluntary license specialty for supervisors. Individuals who self-identify with this specialty are listed on a public roster to provide professionals-in-training with easier access to supervisors.

However, OPR does not verify that licensees who select the specialty meet qualifications to offer supervision. Likewise, OPR does not periodically follow-up with these individuals to confirm that they are providing supervision. Lastly, this specialty is voluntary and not required to provide supervision, meaning that there are likely a large number of supervisors in Vermont who do not have this specialty on their license.

Ultimately, OPR finds that this specialty could be a more useful regulatory tool for both professionals-in-training and supervisors alike.

Stakeholder Feedback

Stakeholders recommend against requiring certification for supervisors. Nearly every mental health profession's national association offers a voluntary certification for clinical supervisors, the requirements for which extend well above and beyond Vermont's own standards. For example, the American Association for Marriage and Family Therapy's (AAMFT) *Approved Supervisor Designation* (ASD*)* requires a 30 hour "Fundamentals of Supervision" training course with a 6-hour refresher course every 5 years.[30] However, although AAMFT is a proponent of their supervisor certification program, association representatives acknowledged in meetings with OPR that to require all MFT supervisors to obtain the ASD would harm Vermont trainees and clients alike by reducing the number of available supervisors. Instead, the AAMFT recommended that in addition to Vermont's current supervisor qualifications, Vermont could allow non-resident supervisors with the ASD certification to remotely supervise trainees in Vermont. The concept of non-resident supervisors is discussed further in *Topic 14: Non-Resident Supervisors*.

Stakeholders support additional training for supervisors. Similar to the feedback from AAMFT representatives, most study participants were not opposed to additional requirements for Vermont's mental health supervisors but noted concerns of increasing costs for supervision. As a compromise, there was nearly unanimous support for supervisor-specific continuing education (CE) coursework. CE hours in the mental health professions are generally not prescriptive, meaning that professionals must obtain a certain number of CE hours in order to renew their license, but are free to pursue relevant education in the subjects of their choosing. This non-prescriptive model is generally considered best practice, as professionals may perform self-assessments and select the trainings which will best serve their needs (as discussed in *Topic 9: Streamlining Opportunities in Continuing Education*). Accordingly,

[30] ASD requirements are available here: https://www.aamft.org/AAMFT/supervision

rather than adding additional CE hours for supervisors, mental health boards can simply require that supervisors obtain a minimum number of CE hours related to supervision skills.

Stakeholders recommend reducing supervision barriers for doctoral psychologists. Some study participants noted that Vermont's standard supervisor three-year practice qualification requirement is sometimes more restrictive than neighboring states. Specifically in the case of doctoral level psychologists, neither Massachusetts, New Hampshire, New York, the American Psychological Association, nor the Association of State Psychology Boards (ASPPB) require or recommend that doctoral psychologists obtain practice experience before offering supervision. These stakeholders argue that doctoral psychologists are trained to provide supervision as part of the doctoral program, and the three-year experience requirement limits these graduates from practicing to the full scope of their education and training:

> *In our view this regulation creates an unnecessary barrier to licensure. We believe that the integrity of doctoral level supervision, in Vermont, is assured by the fact that only APA accredited training sites are providing this supervision.*

Notably, this argument does not apply to masters' level psychologists, or any other mental health profession, all of which license master's-level practitioners.

Rules Considerations

The Office of Professional Regulation recommends that boards consider continuing education requirements for professionals who engage in or plan to engage in supervision. Specifically, OPR recommends that boards require supervisors to obtain supervision-specific CE without adding any additional hours to the total required (per recommendations in *Topic 9: Streamlining Opportunities in Continuing Education*). Many of Vermont's supervising professionals already have a supervisor certification from their respective national associations. The same CE required for these certifications would be acceptable for Vermont's new standard, and it is likely that these professionals are already using their certification CE to meet Vermont's CE requirements.

Additionally, OPR recommends that the Board of Allied Mental Health consider removing inconsistencies related to supervision by nurse practitioners and supervision by MFT's for social workers.

Lastly, the Office of Professional Regulation recommends that the existing supervisor specialty be used as a regulatory tool. The Office proposes further development of the specialty endorsement as a requirement for practitioners to provide supervision services, and that licensees must obtain continuing education requirements for supervision at each renewal period in order to maintain the specialty endorsement. OPR could then revoke the specialty as an enforcement penalty if boards determine such conditions are necessary after a finding of misconduct.

Topic 14: Non-Resident Supervisors

Until recently, most mental health professions required that clinical supervision occur in a face-to-face setting. However, as a result of the COVID-19 pandemic, Vermont's supervision standards were temporarily modified to adopt remote supervision practices. The emergency policy which permits remote supervision has been extended multiple times, and in *Topic 8: Streamlining Opportunities in Supervised Practice*, OPR recommends that remote supervision should now be made permanent in administrative rules.

The shift to remote supervision has highlighted an unintended consequence: non-resident supervision. Although non-resident supervision was not explicitly prohibited prior to the pandemic, in-person supervision requirements made non-resident supervision far less likely. As a result, in this study OPR asked participants whether a professional who has authority to practice in Vermont either through a Vermont license or compact license, should be able to provide remote supervision to a Vermont-resident trainee. Theoretically, non-resident professionals have authority to practice in Vermont, and their remote supervision would be no different for the trainee or the trainee's clients than if the remote supervisor were in-state.

Additionally worth noting is that Vermont has never required that supervised practice hours occur in Vermont. Supervisors need only meet Vermont's qualifications and have an active license in the state where the supervised practice occurs.

Stakeholder Feedback

Stakeholders expressed support for non-resident supervisors. Study participants identify remote supervision as a means to increase access to supervision (see *Topic 8: Streamlining Opportunities in Supervised Practice Rules*). Following that same logic, stakeholders are largely supportive of expanding access to qualified supervisors outside of Vermont if they have a license to practice in our jurisdiction. As the Vermont Psychological Association writes: *There's no real basis for requiring supervisees and supervisors to be in the same state, as long as the supervisor is licensed in Vermont*.

Stakeholders also suggest that expanding access to supervisors outside the state may allow for Vermont's trainees to find supervision under specialists or in niche areas of practice which are not available locally. Further, this policy change would offer additional benefits to professionals-in-training who are individuals of Vermont's marginalized communities, as discussed further in *Topic 20: Barriers to Supervised Practice for Marginalized Groups*.

Rules Considerations

The Office of Professional Regulation recommends that boards continue to allow non-resident professionals to supervise in-state trainees remotely, so long as they are actively licensed in Vermont or, if applicable, are actively licensed in a compact-member state.

Topic 15: Supervision Contracts

Although nearly all of OPR's regulated mental health professions require supervised clinical practice as a condition for licensure, none require contracts between supervisors and trainees. Contracts are an effective way for both parties to understand roles and expectations while creating binding agreements to which both parties can be held accountable. Supervision contracts are standard requirements across the US and in education programs.[31]

Stakeholder Feedback

Study participants were amenable to mandatory supervision contracts, with caveats. Proponents of contracts suggested that binding agreements would provide additional protections to both parties, but especially trainees, for whom there is an asymmetric power imbalance. However, many study participants cautioned against a single, standardized contract, to preserve flexibility in supervision arrangements.

1. *Standardized contracts could help set clear expectations and foster consistency, but they should remain flexible enough to accommodate the diverse needs of trainees and supervisors.*
2. *I do not feel that a standardized supervisor contract is beneficial as it limits the individuality of the supervisor, however I do think it would be helpful to have a "sample" or "model" contract available for those who do not want to create their own.*

Rules Considerations

The Office of Professional Regulation recommends that the Director and boards consider the potential benefits that supervision contracts may offer to supervisors and professionals-in-training. Rather than mandating the use of a specific standard contract, which could be too rigid for all supervision arrangements, OPR recommends boards specify the minimum necessary contract clauses. For example, rules could require contracts to include:

- A section to establish the purpose, goals, and objectives of supervision
- A section outlining the context and content of supervision
- A section identifying the rights and responsibilities of both parties
- A section explaining procedural requirements, for example:
    - Deliverables such case notes, supervised hour logs, billing paperwork, etc.
    - Professional development evaluations
    - Grievances
    - Emergency events
    - Contract termination or changes to terms
- A section defining the financial compensation model

[31] See Appendix F and G for NAADC and Kent State University sample contracts, respectively.

OPR does not recommend any requirement to pre-approve contracts. However, OPR would work with boards to design a sample contract for supervisors/trainees to adopt as a template and then modify for their own needs.

Topic 16: Supervisor Financial Benefit Restrictions

In some of OPR's regulated mental health professions, supervisors are forbidden by rule from benefiting financially from the practice of the trainee.[32] Under these rules, supervisors may sell their services to trainees only for a flat fee (e.g., monthly) or a fixed rate (e.g., hourly). In both the flat fee and fixed rate models, in theory, the supervisor is paid the same amount regardless of the size of the trainee's caseload.

The original rationale for this financial benefit restriction was a concern over conflicts of interest: boards feared that if supervision fees scaled with workload, supervisors would push trainees to take on too-large caseloads. Therefore, the financial benefit restriction was intended to separate the trainee's work volume from the supervisor's financial interests.

The alternative to the financial benefit restrictions is to allow supervisors to collect a portion of the trainees' client fees, sometimes referred to as *practice-based compensation*, *fee-splitting*, or *use of license fees*. The legality of this practice varies across the country by both state jurisdiction and profession type. Opponents of fee splitting fear the practice incentivizes "supervision mills" wherein a supervisor accepts as many trainees as possible to maximize their potential income. Likewise, another concern is that fee splitting will result in self-serving referrals by supervisors to their trainees.

Notably, the administrative rules for social work contain no financial benefit restriction. Instead, they require that "*financial relationships between supervisor and supervisee…be discussed to ensure that both can be completely candid and so that all issues arising from practice and the practice setting can be adequately addressed.*"[33] OPR has not disciplined a greater number of social work trainees than trainees in professions with a financial benefit restriction, which suggests the restriction is not necessary to protect the public from overworked trainees.

Stakeholder Feedback

Stakeholders are confused by financial benefit restrictions. Based on study participant feedback, it is likely that many supervisors currently employ compensation models which unintentionally violate the financial benefit restriction. Confusion only increases when

[32] I.e., LCMHC, LMFT, Psychologists
[33] Social Work Rule 4.11(a)

supervisor and trainee work in professions with different rules—for example, when a psychologist supervises a social work trainee.

Stakeholders identify trainees as vulnerable to financial benefit restriction enforcement. Study participants shared concerns that enforcement of the financial benefits restriction would cause the supervisee to lose hours accrued under that supervisor. Consequently, study participants suggest supervisees may be reluctant to report their disqualifying fee arrangements. This issue raises questions of fairness, as professionals-in-training would bear the brunt of enforcement consequences.

Stakeholders feel the financial benefit restriction is counterproductive. The great irony of the financial benefit restriction is that while its intention is to protect trainees from pressure to increase caseloads beyond what they are comfortable, the resulting flat-rate models often do just that. For example, the larger the trainee's caseload, the more administrative work and liability for the supervisor. Supervisors are therefore more likely to set flat fees which fairly compensate the supervisor in the event that the trainee has more, and not fewer, clients. Thus, the high cost of a flat fee supervision model inherently compels trainees to increase their caseloads:

> *If supervisors issue a set* retainer *fee that is due at the beginning of a supervisory relationship as a way to cover their additional time and liability, supervisees are incentivized to work more hours to offset the one-size-fits-all fees in order to improve their financial ratio (fees to income).*

Additionally, study participants acknowledged the "retainer" model may be especially problematic for trainees who are members of marginalized communities. For more detail, see *Topic 20: Barriers to Supervised Practice for Marginalized Groups*.

Study participants noted that an hourly rate model discourages trainees from seeking guidance from their supervisors outside the minimum required meetings.

> *If supervisors are forced to charge for all time spent on incidental contact with supervisees (for example, if a supervisor were to charge supervisees for time every time they responded to emails, texts and phone calls rather than trusting that this time gets covered over time by the use of license fees), [*supervisees*] would be disincentivized to ask for support between sessions. Not only would this reduce their learning opportunities, but it would increase the risk of clinical or ethical errors being made in client care. Allowing supervisees to contact supervisors freely without charge gives supervisors the opportunity to weigh-in on all safety assessment and planning, clinically critical and time-sensitive decision making, and legal or ethical questions as they arise, real-time, without creating a financial motivation for supervisees to make those decisions alone.*

Stakeholders defend practice-based compensation. Supervisors who engage in practice-based compensation for social work trainees defend the model for its unique benefits. Proponents feel that fee-splitting is the fairest way to compensate supervisors:

> *Supervisees who see more clients and therefore use and benefit from the supervisor's license more pay an appropriately higher aggregate amount in fees for the use of that license. In other words, there is a direct relationship between the use of license fees, the supervisee's gain from the supervisor's license, and the supervisor's costs (in liability, administrative and incidental clinical contact time, and credit card fees on money coming in for supervisees from payers). This does not constitute a supervisor taking a cut – it simply means that the fees are a direct reflection of the supervisee's use of time and resources, allowing the supervisees' fees match the degree to which they are benefiting from a supervisor's license and creating supervisory costs.*

In addition, study participants observe that fee-splitting provides cash-strapped graduates an alternative to paying for supervision out of pocket, which was a widely reported challenge of fixed-rate models. Similarly, feedback suggests that fixed-rate models are too rigid for the complexities of life:

> *[*Fee splitting*] also creates more freedom for supervisees to reduce hours or step away from work, without having to worry about covering fees. For example, in this model there are no fees to be paid if the supervisee is on vacation, medical or maternity leave, or otherwise not working. As their income reduces, so do their fees, which keeps stress and financial strain low for supervisees.*

Lastly, proponents argue that fee splitting—unlike hourly billing of supervisors' time—does not disincentivize supervisees seeking support:

> *Supervisees are encouraged to reach out to me between sessions at no cost, and they are encouraged to schedule more supervision sessions than are required by the state ratio if they find it supportive to do so … many of my supervisees choose to acquire significantly more supervision than is required because it benefits their learning. This supports their development, and also helps me ensure we are providing high quality care to clients.*

Rules Considerations

The Office of Professional Regulation encourages boards, in conjunction with OPR's director, to consider whether financial benefit restrictions are necessary. Paired with mandatory supervision contracts, increased flexibility could attract additional qualified supervisors and make supervision more accessible to trainees.

Topic 17: Supervisor's Evaluation of Trainee Readiness for Independent Practice

Most regulated mental health professions which require supervised practice hours also require a supervision report. Supervision reports provide OPR and boards with the necessary information to determine whether a professional-in-training has met the necessary supervised practice requirements.[34] However, the supervisor's report must also provide an evaluation by the supervisor whether to recommend the trainee for independent practice. OPR asked study participants if the supervisor's evaluation is a fair and necessary barrier, or if the evaluation creates an unnecessary asymmetric power dynamic.

Stakeholder Feedback

Stakeholders emphasize the importance of the supervisor's evaluation.

> *Clinical supervision may very well create some level of power imbalance, but we wouldn't say it's "unnecessary." As you know, mental health is very different from other health care professions regulated by OPR in that mental health clinicians work in an area that has few, if any, tangible and objective measures for diagnosis and outcomes…As with other professions, completing formal training and passing a licensing exam do not ensure that an individual is providing competent services. Having an experienced clinician guide a trainee through initial practice helps to ensure that licensed clinicians have at least some minimum level of competence.*

Stakeholders support standardizing the supervisor's evaluation. Study participants felt that standardizing supervisor evaluations for independent practice would reduce subjectivity and therefore benefit both trainees and supervisors alike.

1. *Standardizing the evaluation and attestation of readiness can be helpful in making the requirements easier to understand and achieve.*
2. *A standardized evaluation process for assessing readiness for independent practice would be beneficial, but it should focus on practical competencies rather than excessive documentation or subjective criteria that could delay progression.*
3. *Standardizing the evaluation and attestation of readiness for independent practice is another area where additional regulation could be helpful. Having clear, consistent criteria across states or jurisdictions for when a supervisee is ready for independent practice would create more uniformity in the profession. However, the evaluation process should remain flexible enough to account for individual differences in experience and learning styles, avoiding a one-size-fits-all approach.*
4. *I believe a standardized option for the evaluation and attestation of readiness would be helpful so long as there is still the opportunity for a narrative account from the supervisor to capture any additional concerns or*

[34] The Board of Psychological Examiners and the Board of Allied Mental Health supervisor report forms are available in Appendices H and I, respectively.

recommendations or strengths that are not represented in the standardized content.

Additionally, study participants acknowledged that standardizing the evaluation would help to prevent bias against professionals-in-training from Vermont's marginalized communities (for more information see *Topic 20: Barriers to Supervised Practice for Marginalized Groups*).

Rules Considerations

The Office of Professional Regulation recommends that the Director and boards consider standardizing the supervisor evaluation process.[35] Likewise, standardizing smaller, more frequent evaluations of competencies may be a more effective approach to ensuring minimum competency for new licensees, as well as protecting against either explicit or implicit bias on behalf of the supervisor.[36]

Additionally, study participants requested that OPR separate the supervised practice log, which records supervised hours, from the supervisor's evaluation tool. For some professions, such as psychology, trainees must undergo supervision by at least two different supervisors and similar recommends are made in rules for both mental health counselors and marriage and family therapists. It does not make sense for the supervision report, which primarily functions as a log of supervised hours, to include an assessment for independent licensure, if the trainee has not yet satisfied the required number of clinical practice hours.

[35] Evaluation competencies may be drawn from each profession's established core competencies. For example, the ASPPB's Position Statement on the Core Competencies at the Point of Licensure, the NASW's Standards for Clinical Social Work, the CCPTP's Counseling Psychology Core Competencies, the AMHCA Standards for the Practice of Clinical Mental Health Counseling, or the AAMFT Marriage and Family Therapy Core Competencies.

[36] Chimea et al., 2020.;

Part 3: Barriers to Entry for Marginalized Communities

Act 117 (2022) requires the Office of Professional Regulation to study the barriers to entry into the mental health professions for Vermont's marginalized communities, including but not limited to individuals who are: Black, Indigenous, or Persons of Color (BIPOC), refugees and new Americans, LGBTQ+ individuals, individuals with low income, individuals with disabilities, and individuals with lived mental health and substance use experience.

Professional regulation intentionally creates barriers to entry as a means to restrict market access to all but qualified individuals. As discussed in *Part 1*, these barriers generally occur in the mental health professions as three separate qualification hurdles: an acceptable education, a passing score on the licensing exam(s), and completion of the requisite supervised practice hours.

NOTE: Act 117's mandate to study barriers to entry for marginalized groups is ***not*** a directive to lower the minimum competency standards in Vermont's mental health professions. Rather, Act 117's goal is to identify how the current qualification standards and competency assessments may create barriers which disproportionately affect applicants from marginalized communities.

Part 3(a): What is Equity in Professional Licensure?

Group "marginalization" refers to exclusion which may occur through either intentional or unintentional means of discrimination. Marginalized groups often experience additional barriers to entry into licensed professions because their social identities are different from the dominant group. **Unintended barriers to access are obstacles that can hinder marginalized groups from fully participating in society, even when there are no explicitly discriminatory policies in place.** In professional licensing, marginalized groups frequently experience unintended barriers simply because the rules and regulations weren't made with their group/social circumstances in mind.

Sameness ≠ Fairness

The difference between equality and equity may be described as perspectives of "sameness" and "fairness." In conditions of equality, everyone receives the same treatment. In conditions of equity, everyone receives the treatment necessary to achieve an equal opportunity.

In professional licensing, **unintentional barriers to entry arise when qualification standards are based on considerations of equality rather than equity**. For professional regulators, this distinction is sometimes challenging. After all, no one is entitled to a professional license: professional regulation exists solely for the purpose of public protection, and a result, all applicants for licensure must prove that they are competent for safe practice. Moreover, in the field of mental health practice it is especially important (sometimes a matter of life or death) that licensed professionals are competent practitioners.

However, **equal practitioner competency requirements and equitable pathways to licensure are not competing goals**. An equal opportunity to prove proficiency for licensure does not diminish a profession's competency requirements.

Qualification Standards ≠ Competence

Every regulated profession has its own minimum competency requirements, i.e., the least knowledge and skills necessary to safely perform regulated services to the prescribed standards of practice. Qualification standards are the administrative barriers used in professional licensing to restrict access to professional practice to qualifying individuals. In the mental health professions, qualification standards may include direct competency assessments such as practicums or supervised practice, but generally also include additional requirements such as specified degrees or licensing exams, which are indirect competency assessments, i.e., a determination of competence *by proxy*.

In professional licensing, unintended barriers arise when qualification standards exclude applicants based on considerations other than competence. **Qualification standards which require achievements outside strict considerations of competence are discriminatory because those standards inherently exclude individuals on a basis other than ability**.

A profession's qualification standards must closely match the profession's minimum competency requirements. When qualification standards are greater than the minimum competency requirements, individuals are inherently excluded from licensure due to unnecessary barriers. Alternatively, when competency requirements are greater than qualification standards, individuals are licensed who do not possess all of the knowledge and skill necessary for safe practice.

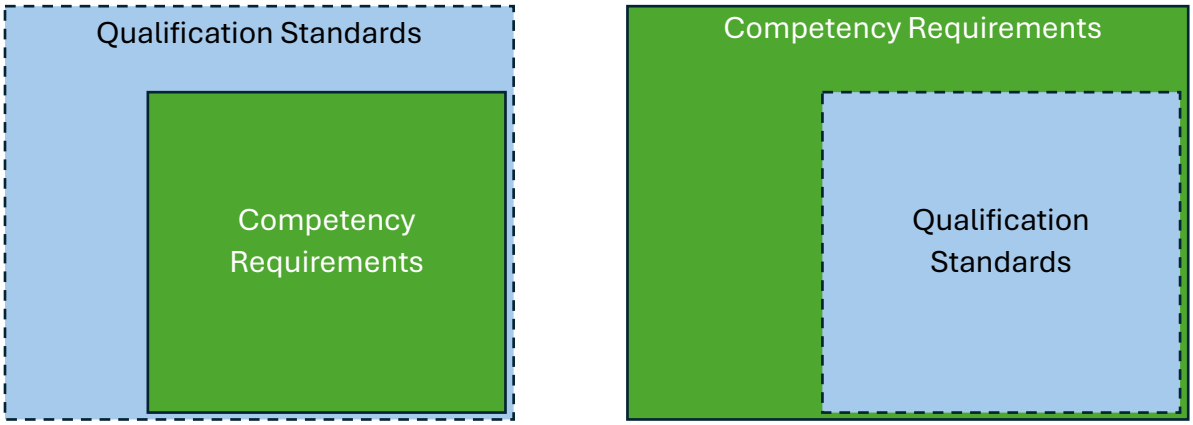

Figure 6: Regulations fail when professional licensure qualification standards do not closely match the minimum competency requirements for safe practice.

Chapter 57 Guidelines for Professional Regulation

26 V.S.A. § 3105 ("Chapter 57") limits the Office of Professional Regulation from engaging in regulatory intervention except when necessary for public protection. Even then, the statute instructs OPR to engage in the *least restrictive method of regulation* necessary. Accordingly, Chapter 57 requires OPR to strike a regulatory balance between dual obligations:

1. OPR must protect the public by ensuring that professionals possess the minimum competencies necessary to practice safely; *yet*
2. OPR must limit regulatory burdens for licensure from becoming superfluous and creating unnecessary barriers to workforce access.

Unintended barriers to licensure for marginalized groups violate Chapter 57 instructions for professional regulation. Act 117 requires OPR to evaluate if Vermont's mental health professional regulations are protecting the public without creating undue burdens for applicants—especially those from Vermont's marginalized communities.

In the following section, this report evaluates the mental health professions' three primary qualification standards—education, exams, and supervised practice—with a specific focus on how the current rules and regulations may disproportionately affect applicants from marginalized groups.

Part 3(b): Barriers to Licensure for Marginalized Groups

Nationally, marginalized groups are underrepresented in the mental health fields:

> *According to 2019 data from the American Psychological Association (APA), about 83% of the U.S. psychology workforce is white … If the psychology workforce had racial parity, about 60% of practitioners would be white, 18% Hispanic or Latino/a, 13% Black or African American, 6% Asian, and 3% other, according to the U.S. Census Bureau. Race isn't the only area of disparity within the psychology workforce. Only 5% of psychologists have disabilities, while 25% of the U.S. population has some kind of disability. That 5% figure has remained stagnant over the last decade. Little research has been done to measure the percentage of psychologists who identify as LGBTQ+, although many LGBTQ+ individuals have reported difficulty finding a therapist that suits them. Studies also show that sexual minority groups experience difficulty finding mental healthcare.*[37]

The Office of Professional Regulation does not have sufficient data on Vermont mental health providers' demographic information to contrast provider demographics with those of Vermont's general public. While OPR invites all professionals to anonymously self-report their demographic information during the license renewal period, the response rate is low. However, it safe to assume that Vermont's mental health professional workforce likely suffers from a lack of representation.

Topic 18: Barriers to Qualifying Education for Marginalized Groups

Generally, individuals from marginalized communities are less likely to attend post-graduate education programs, and when they do, are more likely to leave their education programs before completion.[38] For individuals from marginalized communities, common barriers to education and career achievement include but are not limited to:

- Financial insecurity;
    - Increased price sensitivity;
    - Balancing full-time work and education;
- Insufficient social capital;
    - Lack of access to high-value relationships;
    - Limited professional networks & employment opportunities;
- Lack of representation and cultural mismatching with education programs;
    - Negative academic stereotypes;
    - Low instructor expectations;
    - Microaggressions; and
- Rigid bureaucratic hurdles.[39]

[37] Chamlou, 2024; See also: Lin and Ginsburg, 2021; Torres Acosta et al., 2023.
[38] Walsh, et al., 2021, Bushnell, 2021.
[39] Thiem and Dasgupta, 2022; United States Government Accountability Office (GAO), 2022.

As discussed in *Topic 6: Streamlining Opportunities In Post-Graduate Education Rules,* this study finds the education requirements in some of Vermont's mental health professions are less flexible than those in other states, and offer fewer paths to professional licensure. For individuals from marginalized groups, these limitations may result in additional, inequitable barriers to qualifying education for Vermont licensure.

Stakeholder Feedback

Stakeholders feel the "acceptable" degree determination model is more likely to obstruct individuals from marginalized groups. Individuals from marginalized groups are more likely to experience a disruption or gap in their education.[40] Often, this disruption forces a change to the individual's education plan, including a change to their program/institution. For many applicants, the current emphasis on an "acceptable" degree rather than just necessary coursework, creates an insurmountable financial barrier to professional licensure.

1. *I have almost two full degrees in clinical mental health counseling because credits from my first degree were not honored…I spent an extra year and a half gaining $45,000 in extra untenable school debt in order to retake the same set of curriculum…This is egregiously problematic on a financial level, and also unethical on a personal and educational level.*
2. *The cost that this person has to now pay, and the time that they have to put in in order to go back to school and repeat a majority of the coursework that they needed to complete for their previous degree, just so that they can take one course that cannot be supplemented post degree, is shameful in my opinion. We are desperate for clinicians and then we make the burden too high for those who wish to join this profession.*
3. *For applicants with master's degrees that do not fully meet qualifying or required course work, (even with grants and loans), applicants would have to drastically reduce their workload to take on a full-time master's program vs. taking a few courses.*
4. *We allow out of state transfer and practice but do not recognize our educated applicants that are Rostered.*
5. *Educational standards create barriers on people moving in from out of state - and thereby barriers on people of color coming from communities different from VT.*

Stakeholders feel the "acceptable" degree determination model is more likely to obstruct internationally educated professionals. The Office of Professional Regulation relies on credential evaluation services (CES) to assess the substantial equivalence of international education programs with Vermont's own requirements.[41] However, the "acceptable" degree determination model restricts the potential for course supplementation, and New Americans and refugees are more likely to be unable to afford entirely new graduate degrees.

[40] Liu, 2021.
[41] More information on OPR's foreign education pathways to licensure is available here: https://sos.vermont.gov/opr/regulatory/reducing-barriers/new-americans/

1. *Recognition of International Credentials: Immigrants and refugees who are highly qualified in their professions often face excessive hurdles in getting their qualifications recognized…Addressing these barriers through thoughtful policy changes would create a more equitable licensing system and strengthen the profession as a whole.*
2. *With an MA clinical psych degree since 2000, practicing for 24 years, licensed in Quebec, having taken numerous continuing education seminars, having no complaints or restrictions by the Quebec licensing board, being unable to get licensed in VT (my new home) is frustrating. After 24 years, I am unable to produce required documentation to determine whether my studies are "equivalent" to those in VT.*

Rule Considerations

In *Topic 6: Streamlining Opportunities in Post-Graduate Education Rules*, this report recommends that OPR's Director and Vermont's mental health boards consider expanding pathways to licensure by implementing remedial coursework supplementation plans. The current "acceptable" degree determination model is more restrictive than many jurisdictions in the US from which Vermont accepts professionals through the fast-track endorsement, or interstate licensure compact, pathways. Not only do the current course supplementation restrictions place Vermont-resident applicants at a disadvantage, but the degree-centric qualifications create a "paper ceiling" which is more likely to obstruct applicants from marginalized groups.

Likewise, in *Topic 6*, OPR encourages the Director and mental health boards to consider how a general counseling credential could offer a pathway to licensure for applicants whose education and training may not match the profession-specific approaches through which Vermont's current mental health professions provide care.

Topic 19: Barriers in Licensing Exams for Marginalized Groups

In *Topic 7: Streamlining Opportunities in Licensing Exam Requirements*, this study finds that stakeholders are frustrated by redundant exam requirements, feel exams do not accurately evaluate competency, and are concerned that exams may include implicit cultural biases. These same issues may disproportionately impact applicants from marginalized groups.

Stakeholder Feedback

Stakeholders feel that multiple exam requirements are more likely to create financial barriers for applicants from marginalized groups. Study participants made clear that exams are costly, especially for professionals-in-training with student loan debt, unpaid internships, and supervised practice costs. Individuals from marginalized communities are already more likely

to experience financial insecurity, and as a result, are an applicant group for whom multiple exam requirements may result in disproportionate burdens.[42]

1. *Requiring two exams creates additional challenges for LGBTQIA+ and BIPOC individuals to pay for them. The cost can be prohibitive or cause unnecessary delays in the pursuit of licensure.*
2. *Again, unequal examination practices and unnecessarily high exam and licensing fees are big contributions to the barriers marginalized folks experience.*
3. *First, social and economic class is a factor that impacts marginalized folks, it inhibits their ability to pay for the exam itself or classes to prepare for the exams.*
4. *Cost of Licensing Exams and Application Fees: These expenses disproportionately affect individuals from lower-income backgrounds, many of whom belong to marginalized groups.*
5. *I think requiring two* [exams] *for Counselors is burdensome and I'm not aware of any indication that both improve assessment. The NCE or NCMHCE alone seems sufficient. Vermont is the only state that I have been involved in that requires both…There is a high financial cost to enter this field, and the exam fees add to that.*
6. *It would be helpful if there were financial supports to pay for the EPPP, it has been difficult for me to re-take the exam due to the financial burden of both study materials (~$1,000) required to pass the exam and taking the exam (~$700).*

Stakeholders feel that the current licensing exams lack sufficient accommodations. The Office of Professional Regulation does not draft or proctor licensing exams for the mental health professions. Stakeholders expressed frustration that exam requirements, as set by national organizations and/or examination service providers, are not accommodating for individuals with a non-English language preference, or for individuals with a disability.

1. *Language Barriers: For individuals from immigrant communities or non-English speaking backgrounds, language can be a significant barrier to accessing licensure. If application processes, exams, or continuing education materials are only available in English, this can exclude individuals who may otherwise be qualified but do not have proficiency in English. Providing translation services or exams in multiple languages could help mitigate this barrier.*
2. *Tests being offer only in English. A test taker should not have to combat the additional burden of a test being offered in only their second or third language versus their primary.*
3. *The exam being in different languages would be helpful for this area. This is a nationwide issue, not just a VT issue.*

[42] Harris and Wertz, 2022.

4. *At the age of 62 with some health issues that require more breaks then the current NCMHCE allows is a barrier for me…Also the only place to take the NCMHCE in Vermont is a testing facility in South Burlington which only offers the test at 830am in the morning. I took the NCE in Montreal and was offered a 10am time slot to take the exam. Being allowed to take the exam later in the morning was helpful for me because of my medical issues. I passed the NCE with one try. I have taken the NCMHCE two times at the South Burlington site, both times starting the test at the only time allowed, 830am. I failed both because I ran out of time. The last time I took the NCMHCE with their new format the bathroom at the testing facility was out of order and I needed to go to a second floor bathroom, losing up to 5 to 10 minutes of time. I failed the test with a 70 needing a score of 72. If I did not have time constraints and/or was allowed to take the test later in the morning and/or was able to use a bathroom closer to the testing room I probably would have passed.*
5. *The exam is really hard on neurodivergent providers, and Vermont needs many more of us yesterday or sooner!*
6. *Licensing exams are holistically based in marginalization itself, and are inaccessible to so many kinds of brains, bodies, experiences, and ethics of being. There should be numerous ways to prove your ability to participate ethically and well in this field.*

Stakeholders feel the current licensing exams are implicitly biased. Licensing exams are intended to test the participant's knowledge. However, question content and phrasing may not apply to all cultures or demographics, resulting in biased design elements and an overall assessment bias. For example, the Association of Social Work Boards (ASWB) found that the eventual pass rates for their licensing exams varies significantly by race: White, 90.7%; Asian, 79.7%; Hispanic/Latino, 76.6%; Indigenous, 73.5%; Black, 57.0%.[43] Similar findings apply to the Association of State and Provincial Psychological Boards (ASPPB) licensing exams.[44]

1. *There have been numerous problems with items and structure on the licensing exam that illuminate cultural differences, which have been described in the literature. One excellent example is the Society of Indian Psychologists' Response to the APA Ethics Code (Garcia & The Society of Indian Psychologists, 2014)*
2. *Cultural and Linguistic Bias: Licensing exams and requirements may not account for diverse cultural knowledge, practices, or language differences, which can inadvertently exclude individuals from non-dominant cultures. Including culturally responsive materials and offering exams in multiple languages could mitigate this.*
3. *Exams often do not reflect cultural differences such as emphasis on the family vs the individual or vice versa.*

[43] ASWB, 2022; Apgar and Nienow, 2023.
[44] Sharpless, (2018); Caldwell, 2023.

4. *Cultural values need to be noted. Eye contact and physical closeness are interpreted differently in different cultures as an example. Exams often do not reflect cultural differences such as emphasis on the family vs the individual or vice versa.*
5. *Cultural Competence in Licensing Exams: Licensing exams may be unintentionally biased toward the dominant culture, using language, case examples, or scenarios that are more familiar to white, middle-class applicants and may not fully reflect the experiences or needs of marginalized groups. Individuals from different cultural backgrounds may find it more difficult to navigate these exams if they do not reflect diverse perspectives. Revising exam content to include more culturally diverse and inclusive scenarios could reduce this barrier.*
6. *The exam has a heavy emphasis on concepts and research generated predominantly by white males, making it insensitive to some of the essential skills and knowledge of marginalized groups.*

Rule Considerations

In *Topic 7: Streamlining Opportunities in Licensing Exam Requirements*, the Office of Professional Regulation encourages mental health boards to consider limiting exam requirements to avoid redundant qualifications, and alternative pathways to licensure which do not rely on licensing exams. Individuals from marginalized communities are more likely to experience disproportionate barriers to licensure as a result of examination costs, a lack of exam accommodations, and assessment biases in licensing exam design.

The Social Work licensing boards in Illinois, Rhode Island, and Connecticut have all pursued exam-alternative pathways for certain credentials. The Vermont Board of Dental Examiners recently established a residency option as an exam-alternative to pathway to licensure. OPR encourages Vermont's mental health licensing boards to consider if additional education and supervised practice could provide a similar competency-based approach to licensure which would be substantially equivalent to the current exam pathways.

Topic 20: Barriers to Supervised Practice for Marginalized Groups

The supervised practice period is an essential part of the professional-in-training's education and professional development. However, a critical underrepresentation of mental health providers from marginalized groups has resulted in a severe lack of clinical supervisors from marginalized groups.[45] This lack of representation, paired with the unnecessarily burdensome rules identified in *Topic 8: Streamlining Opportunities in Supervised Practice Rules*, are likely to create additional and disproportionate barriers for individuals from marginalized groups.

[45] Grapin, Lee, and Jaafar. 2015.

Stakeholder Feedback

Stakeholders feel that professionals-in-training from marginalized groups are less able to find supervisors with shared cultural competency or life experiences.

1. *Marginalized individuals often have fewer professional connections or mentors within their communities, making it harder to secure affordable and supportive supervision required for licensure. Initiatives to create mentorship programs or funding for supervision could address this.*
2. *Given the lack of supervisors, I am a trans person stuck with a supervisor who misgenders me. I do not feel like I can find another one I can afford (I've looked).*
3. *As an LGBTQ+ person, it has been difficult to find supervision with people who adequately understand both me and the clients I serve. I have had to educate supervisors on LGBTQ+ affirming practices.*
4. *It would be beneficial for telehealth providers representing BIPOC and other marginalized groups to be approved to offer Clinical Supervision services.*
5. *I wonder about clinicians from marginalized groups might be allowed to arrange for supervision from outside the state of Vermont so as to work with a broader spectrum of supervisors.*
6. *Marginalized folks should have opportunity to study and be mentored by more trained clinicians of similar background, philosophy and experiences.*
7. *I do think we need to do a better job of ensuring marginalized individuals seeking licensure have access to licensed practitioners with similar backgrounds and/or lived experience. I am not sure if that means that OPR works to develop a list of providers that self-identify as having expertise/lived experience, being available and willing to provide supervision to marginalized individuals seeking licensure but I do think we need to offer better support and be better allies*
8. *Access to Supervision: In rural or underserved areas of Vermont, there may be a lack of qualified supervisors, especially those who can provide culturally competent or affirming supervision for marginalized groups. This can be particularly problematic for individuals who require supervision to meet licensure requirements but do not have local access to supervisors who understand their specific cultural or social contexts. Expanding remote supervision options and increasing the availability of diverse supervisors could help address this.*
9. *I think there is a dearth of both supervisors and therapists in Vermont representing various marginalized groups, which results in professionals/trainees from marginalized groups feeling their needs are under-supported and their experience continues to be marginalized…This circles back to the point made earlier that there is no difference in the quality of supervision provided remotely vs in-person, and in fact the quality can be higher, remotely, in specific situations when the trainee/professional is permitted to seek supervision from relevant experts regardless of state lines.*

10. *I'm gay man. I cannot tell you, even in our progressive profession and in our progressive state, how difficult it is to find a place to complete the internship and residency while feeling that one is safe from homophobia.*

Stakeholders feel the accrual restrictions for supervised practice hours are likely to disproportionately affect professionals-in-training from marginalize groups. In *Topic 8: Streamlining Opportunities in Supervised Practice Rules*, this study finds that hourly accrual restrictions, either the minimum necessary to count towards licensure, or (to a lesser degree) the maximum hours a trainee may accrue in a given year, are examples of unnecessary bureaucratic red tape. In the case of professionals in training from marginalized groups, these rules are likely to hinder applicant's efforts to achieve the necessary number of supervised practice hours for licensure, within the necessary timeframe.

1. *The social work administrative rules on current competency requirement that disqualifies all hours if they are engaging in less than 16 hours of clinical work a week and only counting hours in the last 5 years of practice may be inadvertently discriminatory to clinicians with disability's medical needs, caregiving responsibilities or may otherwise be in marginalized categories and assumes a degree of privilege , neurotypical brain type to have a linear path*
2. *I have worked with supervisees with young families who would appreciate the ability to engage in half-time practice but find that difficult to do within the psychology rules (so they have gone for counseling licenses). As I said above, I appreciate the current ability for supervisees to get supervised practice either in an agency/hospital setting or in private practice because I think that allows for fewer barriers to those who need to arrange their own schedules, etc.*
3. *Supervisory practice should have built-in offerings of regular accommodations, no one should be assumed not to have access-needs and it should be possible to do your hours slower than 5 years, and still be able to get licensed.*

Stakeholders also feel that financial benefits restrictions may disproportionately harm professionals-in-training from marginalized groups. As discussed in *Topic 8: Streamlining Opportunities in Supervised Practice Rules*, study participants are concerned that the financial benefits restriction harms trainees with disabilities who achieve supervised hours at a slower rate, in which case a flat fee is a less affordable model. Additionally, there is feedback suggesting the flat fee model is too rigid compared to the realities of modern life, which hinders professionals-in-training from obtaining supervised hours, and suppresses the number of willing supervisors.

1. *This makes it harder for supervisees to choose to carry small caseloads, or to honor their own boundaries and exercise appropriate self-care. The elegance of fees automatically moving in parallel with income is lost.*
2. *I found 4.7(c) to be a hindrance when attempting to gain supervision hours in private practice employment. Since I was salaried, and my supervisor benefitted financially, my options were to either pay someone outside the practice to supervise hours I was already receiving supervision for or work extra hours at a place with a different financial structure. Neither option furthered my professional goals, training, or interests.*

Rule Considerations

In *Topic 8: Streamlining Opportunities in Supervised Practice Rules*, the Office of Professional Regulation encourages mental health boards to simplify the rules for supervised practice requirements. Perhaps the most impactful of these recommendations for professionals-in-training from marginalized groups, are the recommendations to increase access through remote supervision, to reduce burdens by removing minimum hourly accrual restrictions, and expanding compensation options by removing the financial benefit restriction.

The Office of Professional Regulation hopes that increasing supervision opportunities and compensation models will reduce the disproportionate burdens experienced by professionals-in-training from Vermont's marginalized communities.

PART 4: Summary of Recommendations

The Vermont Mental Health Professional Licensing Study was an 18-month process which yielded findings and recommendations on 20 topics related to Vermont's mental health professional rules and regulations. Many of this report's recommendations are intended to work in tandem and may not function effectively if adopted individually. OPR recommends a follow-up regulatory impact assessment in three years to review the effects of this study.

Recommendations to streamline OPR's mental health professional regulatory structure:

- Consolidate the advisor mental health professions into the Board of Allied Mental Health (p.12)
- Expand the member composition of the Board of Allied Mental Health to accommodate the additional mental health professions (p.13)
- Create an executive officer role for the mental health boards (p.15)
- Create trainee credentials for mental health professionals-in-training (p.18)
- Rename the Roster for Non-Licensed and Non-Certified Psychotherapists to the "Roster for Non-Licensed and Non-Certified *Wellness Advisors*" (p.18)
- Create certification pathways for Mustic Therapists and Art Therapists (p. 20)

Recommendations to streamline mental health profession-specific requirements:

- Expand course supplementation pathways to licensure for applicants whose degrees do not meet the "acceptable" degree coursework requirements (p. 26)
- Consider whether the current exam requirements are necessary to ensure provider competency, and if additional alternative pathways to licensure are possible (p. 28)
- Consider how current exam requirements may unfairly burden Vermont resident applicants (p. 28)
- Simplify supervised practice rules to increase trainee flexibility and access (p. 31)
- Amend 18 V.S.A. § 9361(d) to permit recording for training purposes, with client consent (p. 31)
- Consider limiting continuing education rules to reduce regulatory burdens (p. 34)

Recommendations for Supervisor Regulations

- Add administrative rules to explicitly prohibit clinical supervisors from supervising practice outside their areas of expertise (p. 35)
- Consider continuing education requirements for professionals who engage in or plan to engage in supervision (p. 42)

- Consider removing inconsistencies related to supervision by psychiatric nurse practitioners generally, and the supervision of LICSW by MFT (p. 42)
- Utilize the supervisor license specialty as a regulatory tool (p. 42)
- Consider the potential benefits that supervision contracts may offer to supervisors and professionals-in-training (p. 44)
- Consider whether financial benefit restrictions are necessary (p. 47)
- Consider standardizing the supervisor evaluation process (49)
- Separate the supervised practice hour log from the supervisor's evaluation (p. 49)

Recommendation for a regulatory impact assessment of this study

- Perform a regulatory impact assessment of the policy changes following this study, to review:
    - The consolidated mental health board's functionality
    - The role of the executive officer of the mental health boards
    - Impacts of this report to reduce burdens on mental health professionals
    - Impacts of this report to improve supervision quality and access
    - Impacts of this report to improve barriers for marginalized groups
    - A sunrise review of a general counseling credential
    - Any other regulatory changes OPR and the mental health boards deem necessary

The Office of Professional Regulation recommends this regulatory impact assessment should be due no earlier than January 2028, or two years after board consolidation is implemented after legislative revisions and rulemaking – whichever occurs later.

Respectfully submitted to the House and Senate Committees on Government Operations; the Senate Committee on Health and Welfare; and the House Committee on Health Care.

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION

BY:

December 13, 2024

Dylan Bruce
Policy and Research Manager

Date

APPROVED:

December 13, 2024

Michael Warren
Director

Date

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Appendix A: Organization Outreach List

Mental Health Professional Licensure Study Stakeholder Organization Outreach List
American Nursing Association – Vermont
AALC Inc.
ABA Advisors
American Arab, Middle Eastern, and North African Psychological Association
American Art Therapy Association
American Music Therapy Association
Another Way Community Center
Antioch University
Bi-state PCA
Blue Cross Blue Shield
Board of Allied Mental Health
Board of Psychology
Champlain Valley Office of Economic Opportunity
CIGNA Healthcare
Circles of Support and Accountability (COSA)
Designated Agency: Clara Martin Center
Designated Agency: CSAC
Designated Agency: HCRS
Designated Agency: Howard Center
Designated Agency: Lamoille County Mental Health
Designated Agency: NKHS
Designated Agency: Northwestern Vermont Counseling and Support Services
Designated Agency: RMHS
Designated Agency: United Counseling Services
Designated Agency: Washington County Mental Health Services
Disability Rights VT
Federation of Families for Children's Mental Health
Goddard College
Green Mountain Self Advocates
Hireability VT
LADC Advisors
Migrant Justice
MMR, LLC
Music Therapists
Music Therapy Association of Vermont
MVP Healthcare
NAACP-VT (multiple chapters)
NAMI-VT
NASW VT/NH

Appendix A: Organization Outreach List

National LATINX Psychological Association
National Queer & Trans Therapists of Color Network
Northern Vermont University
Office of Professional Regulation
Office of Racial Equity
Otis & Kennedy, LLC
Out in the Open
Outright Vermont
Pride Center of Vermont
PSYA Advisors
Mental Health Regulatory Agencies in Jurisdictions
Multiple interstate license compact organizations
Saint Michaels College
SW Advisors
The Asian American Psychological Association
The Association of Black Psychologists, Inc.
The National Association of Black Counselors
The Root Social Justice Center
The Society of Indian Psychologists
Therapeutic Works
United Healthcare
University of Vermont
UVMMC
VA Hospital/Services
Vermont Abenaki
Vermont Addiction Professionals Association
Vermont Association for Arts Therapists
Vermont Association for Psychanalytic Studies
Vermont Businesses for Social Responsibility
Vermont Care Partners
Vermont Center for Independent Living
Vermont Criminal Justice Centers
Vermont Health Equity Initiative
Vermont Human Rights Commission
Vermont Legal Aid
Vermont Medical Society
Vermont Mental Health Counselors Association
Vermont New American Advisory Council
Vermont Nurse Practitioners Association
Vermont Professionals of Color
Vermont Psychiatric Survivors Network
Vermont Psychological Association
Vermont Works for Women

Appendix A: Organization Outreach List

Vermont Program for Quality in Health Care, Inc
Vermonters for Criminal Justice Reform
VermontPublic Defenders
VocRehab Vermont
VT AOA
VT CNAA
VT DAIL
VT DCF
VT DDC
VT DED
VT DFR
VT DHCD
VT DMH
VT DOH
VT DVHA
VT HEAC
VT OPR
VT ORE
VT ABA
VT ACDL

Appendix B: Stakeholder Survey

OFFICE OF PROFESSIONAL REGULATION

VERMONT SECRETARY OF STATE

Vermont Mental Health Licensing Study - English Survey

Act 117 (2022) instructs the Office of Professional Regulation (OPR) to study mental health professional licensing in Vermont:

1. The possibility of streamlining the licensure of mental health professionals in Vermont;

2. Whether additional regulation of supervisors is necessary; and

3. The barriers for individuals who are BIPOC, refugees, new Americans, LGBTQ+, low income, with disabilities, and those with lived mental health or substance abuse experience.

Over the last year OPR has worked with representatives from professional licensing boards and advisors, as well as professional associations and community organizations, to examine licensing requirements for Vermont's mental health professionals.

Now, OPR invites our mental health professional licensees, as well as individuals who have applied for but not obtained professional licensure, to share their own experiences and feedback.

NOTE: This survey is anonymous and voluntary.

Thank you in advance for your time!

Appendix B: Stakeholder Survey

1. (optional) **Please select your Vermont mental health credential(s) or the credential(s) for which you would apply.**

- [ ] Psychologist (M.A. & PhD)
- [ ] Social Worker (MSW & LISCW)
- [ ] Marriage and Family Therapist
- [ ] Licensed Clinical Mental Health Counselor
- [ ] Alcohol and Drug Abuse Counselor (AAP, ADC, LADC)
- [ ] Applied Behavior Analyst
- [ ] Psychoanalyst
- [ ] Non-Licensed & Non-certified Psychotherapist
- [ ] Professional-in-training (please select relevant profession)
- [ ] Other (please specify)

2. (optional) **EDUCATION**

Do you feel there are any opportunities to streamline rules and regulations for your profession's education qualification requirements?

Do you feel there are any requirements which create unnecessary barriers to entry into the profession?

For example, degree supplementation, in-person education requirements, career-laddering opportunities.

3. (optional) **LICENSING EXAMS**

Do you feel there are any opportunities to streamline rules and regulations for your profession's exam requirements?

Do you feel there are any requirements which create unnecessary barriers to entry into the profession?

For example, alternatives to licensing exams, the number of exams required, exam accommodations (or a lack thereof).

4. (optional) **SUPERVISED PRACTICE**

Do you feel there are any opportunities to streamline rules and regulations for your supervised practice requirements?

Do you feel there are any requirements which create unnecessary barriers to entry into the profession?

For example, number of supervised hours, remote supervision, supervision contracts (or a lack thereof), trainee credentials vs. the Roster.

5. (optional) **REGULATIONS FOR SUPERVISORS**

Do you feel there should be additional rules and regulations for supervisors?

Do you feel additional requirements could create unnecessary barriers to accessing supervision?

For example, supervisor qualification standards, standardized contracts, standardizing the evaluation and attestation of readiness for independent practice.

6. (optional) **CONTINUING EDUCATION**

Do you feel there are any opportunities to streamline rules and regulations for your CE requirements?

Do you feel there are any requirements which create unnecessary barriers to entry into the profession?

For example, number of CE hours, cost, CE redundancy, necessary CE coursework.

7. (optional) **BARRIERS FOR MARGINALIZED GROUPS**

Group "marginalization" refers to exclusion which may occur through either intentional or unintentional means of discrimination. Marginalized groups often experience additional barriers to entry into licensed professions because their social identities are different from the dominant group. Unintended barriers to access are obstacles that can hinder marginalized groups from fully participating in society, even when there are no explicitly discriminatory policies in place. In professional licensing, marginalized groups frequently experience unintended barriers simply because the rules and regulations weren't made with their group/social circumstances in mind.

Can you identify any rules or regulations which contribute to inequitable barriers to licensure for individuals from Vermont's marginalized communities?

8. (optional) **ADDITIONAL COMMENTS**

Please use this space for any additional comments you have about the licensing rules and regulations for Vermont's mental health professions.

Appendix C: Umbrella Board Examples

Examples of Mental Health Umbrella Boards

Kansas

- *Behavioral Sciences Regulatory Board*
- 74-7501:12 board members appointed by governor: two psychologists, two social workers, one professional counselor, one MFT, one master's psychologist or licensed clinical psychologist, one addiction counselor, four public members
- Addiction counselors, behavior analysts, MFT's, professional counselors, master's psychologists, doctoral psychologists, social workers
- The board is comprised of profession-specific advisor committees
    - Meet every other month
    - Discuss matters recommended by board
    - Make recommendations for changes to statutes/regulations
    - Currently 55 individuals volunteer for advisory committees
- https://www.kslegislature.org/li/b2023_24/committees/ctte_h_hhs_1/documents/testimony/20230130_04.pdf

Ohio

- *Counselor, Social Worker, and Marriage and Family Therapist Board*
- Counselor, Social Work, MFT
- Board comprised of 4 counselors, 4 MFT, 2 social workers, 3 public members
- Each profession has "professional standards committees" which have full authority to act on behalf of the board on all matters concerning their respective professionals
    - Committees = profession's board members + 1 public board member
        - Public member cannot serve on more than one standards committee
- https://cswmft.ohio.gov/wps/wcm/connect/gov/ec24f481-e876-4a08-9adb-69ca05be74c8/12-26-2023+CSWMFT+Board+Laws+and+Rules+4757.pdf?MOD=AJPERES&CVID=oV2jqxi
- Professional standards committees can delegate certain reviews (e.g. application for licensure) to board staff

Texas

- *Behavior Health Executive Council*
- Consists of 4 state boards – MFT, Professional Counselors, Psych Examiners, SW
- Council is a "mini OPR" – boards determine rules and qualifications, scope, etc. and the council either approves their proposals or asks for revisions. The council determines fees and performs bureaucracy/enforcement for standards-setting boards.

New Hampshire

- *Board of Mental Health Practice*
- CMHC, LICSW, MFT, Pastoral Psychotherapists, School Social Workers

Appendix C: Umbrella Board Examples

- Board comprised of 1 licensed professional from each profession, 1 member from a community mental health center, 1 member from a community health center, and 3 public members
- An advisory committee for each of the regulated mental health professions chaired by the board member from that profession to advise the board
- A professional conduct investigation committee chaired by a board investigator, comprised of professionals licensed by the board, with a maximum of 12 members; shall serve for no longer than 2 consecutive 3-year terms

Massachusetts

- *Board of Registration of Allied Mental Health and Human Services Professions*
- LICMHC, MFT, Rehabilitative Counselor, Educational Psychologist, ABA

Maryland

- *Board of Professional Counselors and Therapists*
- Professional Counselor, Licensed Graduate Professional Counselor, MFT, Licensed Graduate MFT, LADC, Licensed Graduate ADC, Licensed Clinical Professional Art Therapists, Licensed Graduate Professional Art Therapists
- 13-member board; 4 clinical professional counselors; 3 MFT; 3 LADC; 1 clinical art therapist; 2 public members
- Board cannot take action against a professional without "discussing the proposed action" with a board member of that profession
- The board may create subcommittees where necessary

Arizona

- *Board of Behavioral Health Examiners*
- LPC, MFT, SW, LADC
- 12-member board: 2 SW; 2 LPC; 2 MFT; 2 LADC; 4 public members
- Board shall establish academic review committees for each of the regulated professions, to evaluate

Appendix D: Explanation of Executive Officer Role

EO Role/Responsibilities

The Executive Officer has responsibility to advance OPR's primary mission of public protection by supporting four key components of professional regulation: practice, licensure, enforcement, and education.

Practice

The EO functions as a subject matter expert regarding scope of practice for all license types under the profession. This requires experience as a member of the profession, as well as in depth knowledge of Statutes and Rules, and familiarity with standards and position statements of national organizations that represent the varying license types within the profession.

The EO assists licensees, employers and members of the public in understanding whether specific professional activities fall within or outside an individual licensee's scope of practice based on current Statutes and Rules and national standards. The EO must maintain knowledge of national organizations that are associated with the profession and the practice standards that are recommended by these organizations.

The EO maintains awareness of trends in practice for all license types and identifies the need for statute or rule changes to ensure alignment between regulations and best practice standards. The EO provides subject matter expertise in this regard to General Counsel and OPR leadership to assist in advocacy for statute or rule revision through developing testimony or talking points for legislators.

The EO develops and maintains effective relationships with key stakeholders across the state that represent varying constituencies that have an interest in the profession and its practice standards. The EO effectively engages these stakeholders to achieve consensus and alignment when pursuing legislative changes that impact the profession.

Licensure

The EO functions as a subject matter expert to License Administrators related to applications, applicant qualifications or disqualifying events. The knowledge and expertise of the EO enables them to identify barriers to licensure without compromising entry level competency standards.

Additional support of LA staff and licensees occurs through collaborative efforts with staff, general Counsel and leadership in creating guidance and instruction documents related to licensing procedures and waiver processes as well as recommending alterations to license applications. This work provides clarity and streamlines the application process, reducing the volume of applicant inquiries that require LA staff response thus increasing the time available to LAs to process applications.

The EO is responsible for drafting communications to licensees, employers, and stakeholders to inform them of regulatory changes, Rule changes and licensure requirements. This helps to provide consistency in messaging as well as providing a contact person that members of these groups can reach out to as needed.

Appendix D: Explanation of Executive Officer Role

Enforcement

The EO supports the work of enforcement by providing information and resources that speak to established practice standards of the profession when there is a question of violation of standards of practice, scope of practice or professional conduct. The EO's knowledge of national standards and the professional organizations that publish them provides resources and references to the enforcement team to inform their investigations and validate deviations from practice standards.

The EO works with Case Managers to evaluate licensee compliance with Board orders, evaluate I-team recommendations for alternatives to discipline, establish alternative to discipline contracts and execute those contracts. The knowledge and experience of the EO helps to ensure right touch alternative to discipline approaches that effectively address underlying conduct or failure to meet practice standards.

The EO is an active member of the pre-denial team, reviewing license applications and second chance determination requests for individuals with history of criminal conduct or previous disciplinary action. The EO provides subject matter expertise regarding nexus to the profession and makes recommendations to the Prosecution team related to appropriateness for licensure, and what, if any, warnings or discipline should be put in place to provide the public with knowledge of licensee past convictions or disciplines.

Education

The role of the EO related to Education for the profession includes evaluation of transcripts to assist LA staff in determining substantial equivalency with Vermont requirements, oversight of educational program compliance with Rules, standardization and revision of program reporting tools, and coordinating and facilitating completion of annual reports to the Board.

The EO maintains relationships with Program Administrators and serves as a resource to them for interpreting and complying with Statutes and Rules. The EO provides education to students, faculty and administrators through formal presentations and personal communications related to regulation, licensing and practice.

LCSW Exam Alternative IL P.A. 103-433

Illinois Public Act 103-433, effective January 1, 2024, establishes an alternative to passing the licensing examination in order to become licensed as a licensed clinical social worker (225 ILCS 20/8.2).

The law requires at least one attempt to pass the required licensure examination, and 3000 hours of supervised PROFESSIONAL experience.

Supervised PROFESSIONAL experience may consist of social services to individuals, groups or communities in any one or more of the fields of social casework, social group work, community organization for social welfare, social work research, social welfare administration, school social work, or social work education. Supervised professional experience may also include supervised clinical social work as described in Section 1470.20.

The 3000 exam alternative hours are **in addition to** the 3000 hours of CLINICAL experience required by Rules 68 IAC Section 1470.20.

The 3000 exam alternative hours may be supervised by any of the following professionals:

- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Psychologist (LCP)
- Licensed Psychiatrist (as defined in Section 1-121 of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-121)
- Licensed Advance Practice Psychiatric Nurse (as defined in Section 1-101.3 of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-101.3)

The exam attempt must have been made since 1/1/2019, and the exam alternative hours must not be more than 10 years old.

Illinois LCSW applicants wishing to obtain licensure by the Exam Alternative Pathway must provide to IDFPR VE-SW form(s) (version January 2024 or later) completed by their supervisor(s) to document the exam alternative experience (in addition to any other application materials or documents required for Illinois LCSW licensure.) Completed VE-SW forms may be emailed to fpr.hssunit@illinois.gov or mailed to:

IDFPR
Health Services Section
320 W Washington St.
Springfield, IL, 62786

Appendix F: NAADC Supervision Contract

SUPERVISION CONTRACT (suggested template)

This is an agreement between _____ (Supervisee) and _____ (Supervisor).

The purpose of supervision is to: (e.g., meet requirements for training supervision) _____

Effective Dates: _____; Frequency of Meetings: _____; Duration of supervision session: ____

Type of Supervision: ___ Group; ___ Individual; ____ combination of both

Supervisor's definition of supervision: ___*(clearly provide your definition to promote shared meaning)* __

1. Purpose, Goals And Objectives Of Supervision:

a. To fulfil requirements for training supervision;
b. To promote development of supervisee's professional identity and competence;
c. To (Other) **AS AGREED UPON BY SUPERVISOR AND SUPERVISEE**.

2. Context And Content Of Supervision:

1. The content of supervision will focus on the acquisition of knowledge, conceptualization, and skills within the defined scope of practice.
2. The context will ensure understanding of ethics, codes, rules, regulations, standards, guidelines (including consent, confidentiality/ privacy), and all relevant legislation.

3. **A supervisory record form** will be used to document impressions of each supervisory session. Feedback will be provided at the close of each session. Supervision notes may be shared with supervisee.

4. Rights and Responsibilities of both parties

a. Supervisor Rights

1. To bring concerns/issues about Supervisee's work.
2. To question Supervisee about his/her work and workload.
3. To give Supervisee constructive feedback on his/her work performance.
4. To observe Supervisee's practice and to initiate supportive / corrective action as required.

b. Supervisor Responsibilities

1. To uphold ethical guidelines and professional standards.
2. To make sure supervision sessions happen as agreed and to keep a record of the meeting.
3. To create a supervision file containing supervision records and other documents relating to development and training.
4. To ensure that Supervisee is clear about his/her role and responsibilities.
5. To record the supervision session and to store their copy in the supervision file.
6. To monitor Supervisee's performance.
7. To set standards and assess the Supervisee against these.
8. To know what Supervisee is doing and how it is being done.
9. To deal with problems as they impact on the Supervisee's performance.
10. To support supervisee and the agreed personal development plan.
11. To complete all forms as requested by the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board including a professional disclosure statement of supervisor and supervision logs (http://cswmft.ohio.gov/pdfs/SupvLog.pdf).

c. Supervisee Rights:

1. To uninterrupted time in a private venue.
2. To Supervisor's attention, ideas and guidance.
3. To receive feedback.
4. To set part of the agenda.
5. To ask questions.
6. To expect Supervisor to carry out agreed action or provide an appropriate explanation, within an agreed time frame.
7. To have his/her development/training needs met.
8. To challenge ideas and guidance in a constructive way.

Appendix F: NAADC Supervision Contract

a. Supervisee Responsibilities:

1. To uphold ethical guidelines and professional standards;
2. To be prepared to discuss client cases with the aid of written case notes and / or video / audio tapes;
3. To validate diagnoses, interventions, approaches and techniques used;
4. To be open to change and use alternate methods of practice if required;
5. To consult supervisor or designated contact person in cases of emergency;
6. Implement supervisor directives in subsequent sessions; and
7. Maintain a commitment to on-going counsellor education and the counselling profession.

3. Procedural considerations:

a. Supervisee's written cases notes (plus diagnoses and treatment plans) and audio / video tapes may be reviewed in each session;

b. Issues relating to supervisee's professional development will be discussed;

c. Sessions will be used to discuss issues of conflict and failure of either party to abide by the guidelines outlined in this contract. If concerns of either party are not resolved in supervision, (**NAME OF ALTERNATE PERSON TO WHOM TO MAKE GRIEVANCE TO**) will be consulted; and

d. In event of an emergency, supervisee to contact supervisor. If not available, then contact (**NAME / CONTACT DETAILS OF APPROPRIATE PERSON**).

4. Supervisor's Scope Of Practice - Brief description of Supervisor's work, qualifications and practice

5. Finances/ Insurance

Agreement as to hourly rate for supervision: _____ to be paid by: _____

Malpractice/ liability insurance will be arranged by supervisee: Yes_____ No_____
(If yes, proof of such must be provided as soon as possible.)
Date proof provided, with copy to supervisor _____

This contract is subject to revision at any time, upon the request of either the supervisee or the supervisor. A formal review, however, will be conducted every six months and revisions to the contract will be made only with consent of the supervisee and approval of supervisor.

We agree, to the best of our ability, to uphold the guidelines specified in this supervision contract and to manage the supervisory relationship and supervisory process according to the ethical principles of the CCAA Inc.

_____ _____

Supervisor **Supervisee**

This contract is in effect from **DATE _____** Date of revision or termination: **DATE _____**

Clinical Mental Health Counseling Supervision Contract

This contract serves as verification and description of the counseling supervision provided by

_____(supervisor), to

_____(supervisee), Counselor Trainee enrolled in_____(course title and #) at Kent State University for the_____semester.

PURPOSE, GOALS, & OBJECTIVES

- Monitor and ensure welfare of clients seen by supervisee
- Promote development of supervisee's professional counselor identity and competence
- Fulfill academic requirement for supervisee's practicum or internship
- Fulfill requirements in preparation for supervisee's pursuit of counselor licensure (when applicable)

CONTEXT OF SERVICE

- One (1) clock hour of individual supervision weekly
- Supervision will revolve around counseling conducted with students seen at_____(name of school/agency)
- Individual supervision will be conducted on__(day of the week), from_____to_____(time).
- The supervisor will be adhering to specific models of supervision along with using progress notes and tape review.

METHOD OF EVALUATION

- Feedback will be provided by the supervisor during each session, and a formal evaluation, using the program's standard evaluation of student client skills, will be conducted at mid-term and at the conclusion of the semester for practicum and at the conclusion of the semester for internship. A narrative evaluation may also be provided at mid-semester and at the conclusion of the semester as an addendum to the objective evaluations completed.
- Specific feedback provided by supervisor will focus on supervisee's demonstrated counseling skills, professional behavior, and documentation.
- Supervisee will evaluate supervisor at the close of the semester, or upon changing sites using the program's standard evaluation form for evaluating supervisors. A narrative evaluation may also accompany the objective evaluations.

DUTIES AND RESPONSIBILITIES OF SUPERVISOR

- Examine students presenting complaints and intervention methods
- View tapes of supervisee's counseling sessions outside of regularly scheduled supervision sessions
- Sign off on all student documentation
- Challenge supervisee to justify approach and techniques used
- Monitor supervisee's basic attending skills
- Support supervisee's development as a counselor
- Present and model appropriate directives
- Intervene when student welfare is at risk
- Ensure that ethical guidelines are upheld
- Maintain weekly supervision case notes

DUTIES AND RESPONSIBILITIES OF SUPERVISEE

- Uphold ethical guidelines
- Review counseling session tapes in preparation for weekly supervision
- Be prepared to discuss all student cases; have student files, current and completed student case notes, and counseling session tapes ready to review in weekly supervision sessions
- Justify case conceptualizations made and approach and techniques used
- Complete case notes and place in appropriate student files
- Consult with field placement staff and supervisor in case of emergency
- Implement supervisory directives in subsequent sessions

Appendix G: Kent State Supervision Contract

SUPERVISOR'S SCOPE OF COMPETENCE (IF APPLICABLE)

PROCEDURAL CONSIDERATIONS

- Supervisee's written case notes, treatment plans, and videotapes will be reviewed and evaluated in each session
- Issues related to supervisee's professional development will be discussed
- Sessions will be used to discuss issues of conflict and failure of either party to abide by directives outlined here in contract. If concerns of either party are not resolved in supervision, the practicum instructor and/or Dr. Steve Rainey will be consulted.
- In the event of emergency, supervisee is to contact supervisor at _____

SPECIFIC GOALS FOR THE SUPERVISEE

1. _____
2. _____
3. _____
4. _____
5. _____

We agree, to the best of our ability, to uphold the directives specified in this supervision contact and to conduct our professional behavior according to the ethical principles of our professional association.

Supervisee:_____Date:_____

Supervisee:_____Date:_____

Verification of Submission of Federal/State Background Checks (for School Counseling students only)

My signature serves as verification that the above named student (supervisee) has submitted a copy of their Federal/State Background Checks to our school.

_____

Signature of School Administrator (Principal, Vice-Principal, etc.)

Appendix H: Board of Psychological Examiners Supervisor Report

Secretary of State
Office of Professional Regulation

PSYCHOLOGIST
Supervision Report Instructions

Dear Supervisor:

We appreciate your assistance in our evaluation of your supervisee for licensed and independent practice as a psychologist in the State of Vermont. We attach considerable importance to the supervisor's report in our evaluation of applicants for licensure and ask you to give us a good sense of your supervisee's experience, performance, and character as well as the specific nature of the supervision you provided. Feel free to append additional pages if the space provided is not sufficient for you to give an adequate account of your supervisee's work. Vermont law requires that the supervisor be a licensed psychologist the entire time supervision was provided.

In completing the attached form, we ask that you:

1. Type or print your responses clearly.

2. Respond to all questions or provide an explanation for any omissions. All sections must be completed fully, and omissions explained, or the form will be returned.

3. Provide any additional information which you feel is relevant to our evaluation of your supervisee's ability to engage in the independent practice of psychology.

4. Submit proof your licensure by completing a “Verification of Supervisor Licensure” form and sending it to your state of licensure. You must demonstrate that you held a valid license at the time you supervised the applicant.

   NOTE: The “Verification of Supervisor Licensure” form is not required if your supervisor is licensed in Vermont.

5. Retain a copy of the report for your own files.

6. Forward the completed form and supporting documentation to the address above.

Appendix H: Board of Psychological Examiners Supervisor Report

Secretary of State
Office of Professional Regulation

PSYCHOLOGIST
Supervision Report

Applicant's name in full:

The following information is to be completed by the supervisor. Please write legibly.

Last Name	**First Name**	**MI**

Mailing Address – Street

City	**State**	**Zip Code**

Telephone	**Fax**	**E-Mail**

List below every state in which you hold or have ever held a license to practice as a psychologist:

State	**License Number**	**Date of Initial License**	**Date Expires(d)**

Appendix H: Board of Psychological Examiners Supervisor Report

SUPERVISION REPORT – PAGE 2

Name of practice setting: _____
Address: _____

Type of practice setting (Check One)

Client population served:

____ Clinic	____ Hospital	____ Private Practice	____ Other

Dates and hours of practice and supervision.
If the supervision is ongoing state the current date – do not state: "In Progress."

Supervision Began MM/DD/YY:		Supervision Ended MM/DD/YY:	

	Total number of weeks of supervised practice.
	Total number of hours of supervised practice.
	Number of individual supervision hours the supervisee received.
	Number of group supervision hours the supervisee received per week.
	Total number of supervision hours the supervisee received.

Please describe the supervisee's specific duties.

Appendix H: Board of Psychological Examiners Supervisor Report

Print as many pages as you need.

SUPERVISION REPORT – PAGE 3

Please provide a detailed description and assessment of the supervisee's performance, including but not limited to: 1) clinical skills supervised, 2) the ethical practices reviewed, and 3) professional readings covered.

Appendix H: Board of Psychological Examiners Supervisor Report

SUPERVISION REPORT – PAGE 4

RECOMMENDATION FOR INDEPENDENT PRACTICE

Please indicate below whether or not you recommend this applicant for independent practice. Please note if you would restrict this applicant to particular areas of clinical practice.

Do you recommend this applicant for independent practice?	Yes	No

STATEMENT OF SUPERVISOR

I hereby certify that I am not a spouse, life partner, former spouse, or family member, or an employer, financial partner, or shareholder in the same counseling enterprise, or a person who gains financially from the practice of the applicant.

I hereby certify that I have been licensed and have been in good standing, no fewer than three years, in a permitted supervisory profession before commencing supervision toward this applicant's licensure.

I hereby certify that all information I have provided herein is true and accurate to the best of my knowledge.

_____ _____

(Signature of Supervisor) **(Date)**

Mail to: Diane Lafaille, Office of Professional Regulation, 89 Main Street, 3rd Floor, Montpelier, VT 05620-3402

Appendix I: Board of Allied Mental Health Supervisor Report

Secretary of State
Office of Professional Regulation

ALLIED MENTAL HEALTH
Supervision Report Instructions

Dear Supervisor:

We appreciate your assistance in our evaluation of your supervisee for licensed and independent practice as a Clinical Mental Health Counselor in the State of Vermont. We attach considerable importance to the "Supervision Report" when we evaluate applicants for licensure. We ask you to give us a thorough description of your supervisee's experience, performance, and character as well as the specific nature of the supervision you provided. Feel free to add additional pages if the space provided is not sufficient for you to give an adequate account of your supervisee's work.
In completing the attached form, we ask that you:

1. Type or write your responses clearly and legibly.

2. Respond to all questions or provide an explanation for any omissions. If omissions are not explained the form will be returned.

3. Provide any additional information which you feel is relevant to our evaluation of your supervisee's ability to engage in the independent practice of mental health counseling.

4. Provide verification of your license. The "Verification of Supervisor Licensure" form must be sent to this Office directly from the licensing authority of the state in which you were licensed at the time you provided supervision. This form only needs to be completed if you are not licensed in Vermont, or if you were licensed in another jurisdiction when the supervision took place.

5. Retain a copy of everything you submit.

6. Forward the completed form and supporting documentation to the address below.

NOTE: The supervision requirement is 3,000 hours of supervised practice over a minimum two-year period, commencing no earlier than the completion of the graduate program. Of the 3,000 practice hours, 2000 hours must be direct service, with the additional 1,000 hours in either continued clinical practice or a combination of related services in a clinical supervisory setting. Please refer to 26 V.S.A. § 3261(2) for the definition of a clinical mental health counseling setting. The supervised practice must include 100 hours of face-to-face supervision. Face-to-face supervision is conducted in the formal setting of an office, clinic, or institution and may be either in an individual setting, between the supervisor and the applicant, or in a group setting, including the supervisor and up to six trainees. Of the100 hours, 50 must be in an individual setting. The required ratio of supervision to supervised practice is 1:30; one hour of supervision per 30 hours of supervised practice. The 1:30 ratio applies to each supervisor and practice setting.

Appendix I: Board of Allied Mental Health Supervisor Report

Secretary of State
Office of Professional Regulation

ALLIED MENTAL HEALTH
Supervision Report

Applicant's name in full:

The following information is to be completed by the supervisor. Please write legibly. Please mail to Diane Lafaille at the address above.

Last Name	**First Name**	**MI**
Mailing Address – Street		
City	**State**	**Zip Code**
Telephone	**Fax**	**E-Mail**

List below every state in which you held a license to practice three years prior to and during the time the supervision took place. Title of your professional license: _____

State	**License Number**	**Date of Initial License**	**Date Expires(d)**

Appendix I: Board of Allied Mental Health Supervisor Report

SUPERVISION REPORT – PAGE 2

Name of practice setting _____

Address _____

Type of practice setting (Check One)

____ Clinic	____ Hospital	____ Private Practice	____ Other

Dates and hours of practice and supervision.
If the supervision is ongoing state the current date – do not state: "In Progress."

Supervision Began MM/DD/YY:		Supervision Ended MM/DD/YY:	

	Total number of months.
	Total number of <u>direct</u> practice hours worked.
	Total number of <u>indirect</u> practice hours worked.
	Grand Total number of <u>direct and indirect</u> practice hours worked.
	Total number of hours of individual supervision received.
	Total number of hours of group supervision received.
	Total number of individual and group supervision received.

Appendix I: Board of Allied Mental Health Supervisor Report

SUPERVISION REPORT – PAGE 3

DESCRIPTION OF SUPERVISION - Please describe in detail the specific nature of supervision. Describe the supervisory methods and the nature of the issues dealt with in supervision.

ASSESSMENT OF PERFORMANCE - Please provide a critical evaluation of the applicant's performance and competence, noting strengths, weaknesses and areas for improvement.

Appendix I: Board of Allied Mental Health Supervisor Report

RECOMMENDATION FOR INDEPENDENT PRACTICE - Please indicate below whether or not you recommend this applicant for independent practice. Please note if you would restrict this applicant to particular areas of clinical practice.

Do you recommend this applicant for independent practice?	Yes	No

STATEMENT OF SUPERVISOR

I hereby certify that I am not a spouse, life partner, former spouse, or family member, or an employer, financial partner, or shareholder in the same counseling enterprise, or a person who gains financially from the practice of the applicant.

I hereby certify that I have been licensed and have been in good standing, no fewer than three years, in a permitted supervisory profession before commencing supervision toward this applicant's licensure.

I hereby certify that all information I have provided herein is true and accurate to the best of my knowledge.

_____ _____

(Signature of Supervisor) **(Date)**

Appendix I: Board of Allied Mental Health Supervisor Report

Secretary of State
Office of Professional Regulation

ALLIED MENTAL HEALTH
Verification of Supervisor Licensure

Name of applicant applying for licensure:	

Supervisor: Complete the first section of this form and have the state in which you performed the supervision complete the rest.

Licensed as a:				
	First Name		**MI**	**Last Name & Title (Jr., Sr., II**
	Mailing Address:	**P.O. Box**		
		Street/Apt #		
		City/State/Zip		
		Country		

I hereby authorize the License Agency to furnish to the Vermont Office of Professional Regulation the information requested below.

Signature_____ **Date:** _____

Information Below to be Completed by the Licensing Agency:

License #		**Date Issued:**		**Date Expired:**	
License as a:					
Licensed By:		**Examination/Education**	**License Status**		**Active**
		Endorsement/Reciprocity			**Inactive**
		Waiver			**Lapsed**
Has this license ever been encumbered in anyway (revoked, suspended, limited, surrendered, restricted, placed on probation)? ***If yes, attach a copy of the decision.***				**Yes**	**No**
Signature of person completing form:				**Date:**	
State Completing this form:		**City/State:**		**Telephone:**	